DEPARTMENT OF THE ARMY
RAYMOND W. BLISS ARMY HEALTH CENTER
FORT HUACHUCA, ARIZONA 85613-7079

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Medical Services

INFECTION CONTROL HANDBOOK

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1. HISTORY: This is a revision of this publication.

2. PURPOSE AND SCOPE:

2.1 This Infection Control Policy and Procedure Pamphlet is established to convey the basic policies and procedures for the Infection Control Program at Raymond W. Bliss Army Health Center to include outlying clinics. It should be used to supplement each area's Infection Control Guidelines. These policies and procedures are necessary to prevent and control clinically acquired infections and to safe guard the health of the personnel assigned to this facility. This publication will be reviewed annually and updated as indicated by the Infection Control Committee.

2.2 This document is required reading for all RWBAHC personnel and will be available for reference on the RWBAHC intranet as well as on the O drive in the Infection Control folder.

2.3 This guide constitutes the standard of practice in Infection Control and is approved by the Infection Control Committee. The use of trade names is for identification only and does not constitute endorsement by the Raymond W. Bliss Army Health Center Infection Control Committee.

2.4 Statement of Authority: see Appendix A

3. REFERENCES.

3.1 Friedman, C., Petersen, K.H., Infection Control in Ambulatory Care. (current edition). Jones and Bartlett Publishers, 40 Tall Pine Drive, Studbury, MA 01776.

3.2 Joint Commission on Accreditation of Healthcare Organizations Standards for Ambulatory Care (current edition). Joint Commission Resources, One Renaissance Blvd. Oakbrook Terrace, IL 60181.

3.3 Center for Disease Control. www.cdc.gov.

3.4 AORN Inc.,(current edition) Recommended Practices and Guidelines: Care and Cleaning of Instruments and Powered Equipment., Denver, Co., AORN, Inc.

3.5 MEDDAC Memo 15-1, COMMITTEE MANAGEMENT

3.6 MEDDAC Memo 40-38, EMPLOYEE HEALTH

3.7 MEDDAC Memo 40-145, TUBERCULOSIS PREVENTION PROGRAM

3.8 40 Code of Federal Regulations

3.9 Operating Room SOP for Infection Control

4. GENERAL.

4.1 Infection control mission: The Infection Control Program at Raymond W. Bliss Army Health Center is designed to support the mission of the Health Center and to optimize the health and fitness of the Fort Huachuca community. The community served by this Health Center consists of active duty soldiers, retired personnel, and their dependents. Approximately 60 surgical procedures are done each month in the surgical suites, all of which are same day procedures.

4.2 Rationale: The infection control process is based on sound epidemiologic principles and nosocomial/health care acquired (HCA) infection research.

4.3 Scope: This publication is applicable to all personnel assigned, attached or employed by Raymond W. Bliss Army Health Center. RWBAHC is an ambulatory-care practice setting. An ambulatory-care practice setting may be defined as one that provides direct health care services to patients for acute and chronic conditions that do not reside overnight (e.g., medical offices and clinics, dental offices, chiropractic offices emergent-care centers, and ambulatory-surgery centers). Many patients who once required hospitalization are now managed totally as outpatients. Ambulatory care now comprises variable practices in highly variable sites caring for a diversity of patients in many different levels of wellness. Different types of invasive procedures are performed with a wide variety of instrumentation in examination rooms, procedure rooms, and in

the operating rooms. In contrast to inpatient health care acquired infections, infections transmitted in outpatient settings are neither systematically monitored nor likely to be detected by routine surveillance. There is now an increased focus on the prevention of infection and control programs as more invasive and diagnostic procedures are performed.

4.4 Host resistance: Many conditions compromise a patient's ability to fight infection. These include pre-existing underlying diseases, immunosuppressive drugs, antibiotic therapy, treatments which provide a portal of entry for microorganisms (e.g. surgery, IV therapy, and urinary catheters), reusable equipment, and our Health Center’s microbial population. Infection control aims to reduce the impact of these conditions through aseptic technique, sanitation, and the separation and transfer of patients with infectious diseases requiring hospitalization. This will be accomplished though administrative controls, work practice controls, and personal protective equipment.

5. INFECTION CONTROL PROGRAM.

5.1 Goals: The goals of the Raymond W. Bliss Army Health Center infection control program are:

5.1.1 To outline procedures and responsibilities necessary to provide an effective response to public health emergencies involving communicable diseases.

5.1.2 To prevent or reduce the occurrence of health care acquired infection;

5.1.3 To prevent or reduce cross-infection to patients and personnel;

5.1.4 To refine and improve patient care. To meet these goals, all disciplines and levels of personnel must participate in the program with complete cooperation, open communication, and strict adherence to all policies and procedures.

5.2 Structure: The Infection Control Program at Raymond W. Bliss Army Health Center is managed by the Infection Control Committee and the Infection Control Officer. To accomplish these goals, the program performs the following essential functions:

5.2.1 Public Health Emergency Response Plan. See Appendix D

5.2.2 Formulation of policies and procedures to prevent and control infections.

5.2.3 Develop and monitor education programs designed to enhance awareness of the prevalence, prevention, and transmissibility of infections.

5.2.4 Epidemiological surveillance for the occurrence of infections in patients and staff within the Health Center.

5.2.5 Formulation and coordination of effective intervention activities based on data generated by surveillance and other sources.

5.2.6 Provide definitions of health care acquired infections for surveillance purposes and to provide for early, uniform identification and reporting of infections and to determine pertinent infection rates.

5.2.7 Maintain a practical system for reporting, evaluating, and maintaining records of infections among patients and personnel. This includes assignment of responsibility for the ongoing collection and analytical review of such data, as well as for required follow-up action.

5.2.8 Continual review and evaluation of all aseptic, isolation, and sanitation techniques employed in the Health Center. Such techniques shall be defined in written policies and procedures.

5.2.9 Write policies defining the specific indications for isolation requirements in relation to the medical condition involved. Assure that the quality of care, including nursing care and the use of monitoring and other special equipment, is not compromised for any patient.

5.2.10 Provide preventive, surveillance, and control procedures relating to the inanimate Health Center environment, including sterilization and disinfection practices, Central Material Service, housekeeping, laundry, engineering and maintenance, food sanitation, and waste management. Such procedures shall be evaluated on a continuing basis and revised as necessary.

5.2.11 Provide for all necessary laboratory support, particularly microbiological and serological.

5.2.12 Provide input into the scope and content of the employee health program.

5.2.13 Orient all new employees as to the importance of infection control, personal hygiene, and their responsibility in the program, with documented in-service education for all departments/services relative to infection prevention and control.

5.2.14 Coordinate with the medical staff on actions relative to the findings from antibiotic utilization review. The ongoing monitoring of antibiotic usage in the Health Center is a medical staff responsibility documented through the Medicine Utilization Evaluation (MUE) Committee.

5.2.15 Control of traffic in all areas, including the monitoring of visitor policies.

5.2.16 Development and revision of all forms used for the collection and collation of data relative to the program.

5.2.17 A mechanism for the initiation, approval, and review of results of all special studies relative to infection control.

5.2.18 Institution of antibiotic susceptibility/resistance trend studies as appropriate.

5.2.19 Consultation relative to the purchase of all equipment and supplies used for sterilization, disinfection, and decontamination purposes.

5.2.20 Monitoring of all findings from any patient care performance improvement activities that relate to infection control.

5.2.21 Evaluation of Health Center disposal systems, for all liquid and solid wastes.

5.2.22 Periodic review of cleaning procedures, agents, and schedules in use throughout the Health Center. Consultation relative to major changes in cleaning products or techniques will be done annually.

5.3 Special Studies:

5.3.1 When a problem or question is brought to the attention of the Infection Control Officer or any committee member, a special study may be requested.

5.3.2 The Infection Control Committee will determine the need for the study.

5.3.3 Any problem or hazard that poses an immediate threat falls under the purview of the Statement of Authority and immediate action is taken.

5.3.4 The study may be performed by the Infection Control Officer, Infection Control Committee or the person/clinic area that identified the problem.

5.3.5 The Infection Control Committee reviews the results of the study and findings are distributed to the medical and nursing staff as applicable.

5.3.6 Hand washing: THE SINGLE MOST EFFECTIVE MEASURE FOR THE PREVENTION OF INFECTION AND CROSS-INFECTION IS HAND HYGIENE. An alcohol-based rub may be used before and after contact with patients, before medications are prepared or handled, and after removing gloves. Thorough hand washing with soap and running water must be accomplished in the following circumstances: (CDC guidelines)

5.3.7 Hands are visibly soiled

5.3.8 After dressing changes

5.3.9 Following personal hygiene

5.3.10 Before handling or serving food.

5.3.11 Employee Health and Staff Awareness: The Infection Control Program includes the health and protection of Health Center personnel, as well as patients. It is imperative that personnel be cognizant of sources of infection and adhere to good techniques to protect themselves. The exams and screening programs provided by Preventive Medicine Wellness and Readiness Service (PMWARS) and Occupational Health are a further means of

protection, and require the full cooperation and participation of all employees. Personnel must be aware of infections in themselves and act responsibly to prevent cross-infection to patients and co-workers. Details concerning employee health may be found in RWBAHC Memo 40-5 Employee Health.

5.4 IC Committee: Covered in Memo 15-1 Committees and Minutes

5.5 Job Description of Infection Control Officer. Appendix B

5.6 Outbreak Plan: Procedures to follow in case of an outbreak Appendix C

6. DEFINITIONS FOR SURVEILLANCE OF INFECTIONS

6.1 INFECTION: Infection is the presence of an organism(s) in body tissues or fluids, accompanied by a clinically adverse effect, either locally or systemically.

6.2 COLONIZATION: Colonization is the persistence of organisms on the skin, or mucosal surfaces without a clinically adverse effect being present.

6.3 NOSOCOMIAL INFECTION: Nosocomial infections are: (According to the CDC’s Definition on Nosocomial/Health Care Acquired Infection)

6.3.1 Infections that occur during a visit to the Health Center which are not present or incubating upon Health Center treatment. Infections with onset after discharge are also considered nosocomial/Health Care Acquired (HCA), if the infecting pathogens are judged to have been acquired during visitation.

6.3.2 Infections listed by an attending physician as HCA (with or without supporting data). Clinical impressions are important but if overwhelming evidence of clinical data is present that disputes the presence of a HCA infection, the infection will not be classified as HCA.

6.3.3 Appearance of clinical infection at a new and different site, even with the same organism as the original infection will be classified as a HCA infection.

6.3.4 Appearance in a culture of new and different organisms from a previously described site of HCA infection will be classified as a HCA infection, if there is a coincidental clinical continuation or deterioration in the patient's condition.

6.4 SURGICAL WOUND CLASSIFICATIONS. The Centers for Disease Control and Prevention (CDC) recommends routine surveillance for surgical site infections; accrediting agencies such as the Joint Commission for Accreditation of Healthcare Organizations require it. Surveillance identifies clusters of infection, establishes baseline risks for infection, provides comparisons between institutions or surgical specialties, identifies risk factors, and permits evaluation of control measures. Achieving these goals requires health-care systems to have access to different information types. Wound classification assists in determining the extent of wound contamination during surgery, and thereby provides a tool for determining whether an infection is HCA or community-acquired. The classification scheme presented here is that recommended by the American College of Surgeons Committee on Control of Surgical Infections of the Pre- and Postoperative Care Committee.

6.4.1 Clean (Class I) - has the least potential for contamination at the time of surgery.

- A nontraumatic wound in which no inflammation or infection was encountered, no breaks in sterility occurred, was elective and primarily closed, and the respiratory, alimentary, and genitourinary tracts were not entered.

- Examples include (but not limited to):

Extraction of lens
Repair of Inguinal Hernia/Varicose Vein stripping
Mastectomy/Breast Biopsy
Operations on Muscles, Tendons, Fascia, and Bursa
Laminectomy/Thyroidectomy
Craniotomy
Abdominal Oophorectomy, Ovarian Cystectomy, Salpingoophorectomy Abdominal Ligation and Division of Fallopian Tubes Laparoscopy
Arthroscopy

6.4.2 Clean-contaminated (Class II) - clean, but systems with endogenous flora are involved.

- A nontraumatic wound in which a minor break in sterility occurred or in which gastrointestinal, genitourinary, or respiratory tracts were entered without significant spillage. No inflammation is encountered.

- Examples include (but not limited to):

Appendectomy (incidental)
Cholecystectomy without inflammation or infection (open or Laparoscopic)
Hemorrhoidectomy
Resection of Small Intestine or Colon (without infection or gross spillage)
Vaginal Ligation of Tubes
Hysterectomy/Hysteroscopy
D and C (without infection)
Caesarian Section
Routine Vaginal Delivery
Episiotomy/Circumcision/Vasectomy
Tonsillectomy/NSR/Oral Surgery
Myringotomy

6.4.3 Contaminated (Class III).

- Any fresh traumatic wound (less than 8 hours) from a relatively clean source, or an operative wound in which there is a major break in sterility, gross spillage from the stomach or duodenum, or entrance into the genitourinary or biliary tracts in the presence of infected bile or urine. Includes incisions encountering acute, nonpurulent inflammation.

- Examples include (but not limited to):

Burn Debridement (immediate)
Pilonidal Cystectomy
Appendectomy (acute)
Resection of Perforated Duodenal Ulcer
Cholecystectomy with inflammation

6.4.4 Dirty (Class IV).

- Traumatic wound with delayed treatment (more than eight hours), fecal contamination, foreign body (bullet), or retained devitalized tissue. Includes operative wounds in which acute bacterial inflammation or a perforated viscus is encountered, or in which clean tissue is transected to gain access to pus.

- Examples include (but riot limited to):

Perirectal Fistulas
Rectal Abcess
Perforated Appendix
Perforated Diverticuli
Any abdominal procedure in presence of peritonitis

6.4.5 Examples of minor breaks in sterility include glove punctures and wet sterile fields without barriers.

6.4.6 Examples of major breaks in sterility include use of unsterile instruments, drapes, or supplies, perspiration in the wound, unsterile foreign bodies in the wound, and insects in the operating suite.

6.4.7 For multiple procedures, classify case according to the dirtiest rating, i.e. hernia repair and tonsillectomy = Class III.

6.4.8 Documentation. The OR nurse will document the classification on the Operation Request and Worksheet under Septic. This will also be entered on the Register of Operations.

7. ISOLATION

7.1 General: Isolation precautions are designed to prevent the spread of microorganisms among patients, personnel, and visitors. Since agents and host factors are more difficult to control, interruption of the chain of infection in the Health Center is directed primarily at transmission. The isolation precautions that will be used at R.W. Bliss Army Health Center are specific to Ambulatory Care. Category specific is a simple system that requires patient care personnel to learn only a few

set routines for applying isolation precautions (7 categories). Due to the high turnover in personnel at R.W. Bliss Army Health Center, the category system has been selected to facilitate provision of optimum patient care.

7.2 Responsibilities

7.2.1 The patients' Primary Care Manager (PCM) is responsible for the written order to specify the patient(s) to be isolated.

7.2.2 The charge nurse of the clinic is responsible for initiating isolation precautions based on sound judgment, pending notification of the PCM. The Charge nurse will also notify the Infection Control Officer.

7.3 Procedures:

7.3.1 Initiation of Isolation precaution must focus on procedures to interrupt transmission.

7.3.2 Specific strategies to control the spread of infectious diseases must be developed by Ambulatory Care Facilities.

7.3.3 Components should include: hand hygiene; use of barriers (glove, gowns, and face protection); patient placement (waiting rooms, examination room, rash rooms, precaution rooms);.equipment; cleaning

7.4 Common Communicable Diseases in Ambulatory Settings (Isolation Precautions: C-contact precautions; D-droplet precautions; A-airborne precautions; S-standard precautions ** C if diapered or incontinent)

Acquired immune deficiency syndrome	S
Adenovirus infection in infants and young children	D,C
Anthrax	S
Antibiotic-resistant microorganisms	C
Chicken pox	A,C
Conjunctivitis	S
Cytomegalovirus infection, neonatal or immunosuppressed	S
Diphtheria	
Cutaneous	C
Pharyngeal	D

Gastroenteritis		
E. coli		S
Giardia lamblia		S
Rotavirus		S
Salmonella	S	
Shigella		S
Gonorrhea		S
Hepatitis		
A	S	
B	S	
other viral	S	
Herpes Zoster		
Disseminated		A,C
Localized	S	
Human immunodeficiency virus (HIV)		S
Influenza		D
Lice	C	
Measles (rubeola)		A
Meningitis		
Viral	S	
H. influenzae		D
N. meningiditis		D
Mumps		D
Parvovirus B 19 (Fifth disease)		D
Respiratory disease, infants and young children		C
Rubella		D
Scabies		C
Streptococcus, Group A (e.g., strep throat)		
Adults		S
infants and children		D
Syphilis		S
Tuberculosis, pulmonary		A
West Nile Virus		S
Whooping cough (pertussis)	D	
Wound		
No dressing/dressing does not contain drainage	C	
Dressing covers and contains drainage		S

7.5 An understanding of the outpatient facility and air flow patterns can assist in the development of Isolation Procedure Protocols. The protocols should include scheduling potentially communicable patients at the end of the day, quickly triaging patients, closing the door of the examination room while the patient is waiting, and limiting access to the patient.

7.6 Education:

7.6.1 Infectious diseases account for about 20% to 30% of physician office visits. Exposure can occur in waiting areas or any area where many people congregate. Avoiding overcrowding, decreasing wait times, triaging patients as soon as possible and having possible communicable patients wait in a precaution room(if available)rather than the waiting room can reduce exposure.

7.6.2 Keeping patient information confidential and providing illness information to the provider is essential. A method must be established to inform staff of appropriate precautions, such as a door sign. Some information must be reported to the local health department.

7.6.3 When transporting patients to another facility or within the Health Care Facility the patient must wear appropriate garb to protect staff members. If a patient is transported to another facility inform the necessary staff members.

7.6.4 The education of the patient and family members regarding the reason for isolation precautions is important to ensure their compliance and to answer any questions.

7.6.5 The routine use of standard precautions will greatly reduce the transmission for conditions other than those of airborne-spread diseases.

8. REPORTABLE DISEASES (See MEDDAC MEMO 40-38 Communicable Disease and Preventable Disease Reporting)

9. STANDARD PRECAUTIONS:

9.1 Applicability: All Health Care Worker's (HCW) will routinely use appropriate standard precautions in the care of all patients when contact (or potential contact) with blood or body fluids, non-intact skin, and mucous membranes is anticipated.

9.2 General: Information, guidelines, and other references is a summary from the CDC and is of importance to Ambulatory Care.

9.3 Definitions:

9.3.1 Health Care Workers(HCW) - all Health Center employees (active or reserve military, civilian or contract), students, and volunteers whose work may involve direct contact with human blood and body fluids.

9.3.2 Standard precautions – This precaution is designed for the care of all patients regardless of their diagnosis.

9.3.3 Blood - blood, blood components, and products made from human blood.

9.3.4 Body fluids - all body tissues and body fluids that may potentially harbor contagious microorganisms. Body fluids include, but are not limited to, body tissues, cerebrospinal fluid, feces, nasal or respiratory secretions, non-intact skin, pericardial fluid, peritoneal fluid, pleural fluid, saliva, semen, sputum, synovial fluid, urine, vaginal secretions, vomitus, breast milk, or amniotic fluid.

9.3.5 Blood borne pathogen - microorganisms which cause disease in humans that are present in human blood, human blood components, products made from human blood

9.4 Rationale: Standard precautions are designed for all patient care regardless of their diagnosis. The underlying concept is that the source for most potentially infectious microorganisms is the colonized body substances of humans, whether the person is infected or not. The precautions apply to blood, all body fluids, non-intact skin, and mucous membranes. Other terms used for similar types of precautions are body substance isolation (BSI) and body substance precautions. The purpose is to reduce risks to patients through cross-transmission of microorganisms via the hands of healthcare workers. This type of precaution is especially valuable in ambulatory care settings because staff members often do not know the identity or even suspect the presence of a pathogen when a patient is initially seen.

9.5 Standards:

9.5.1 Use with all patients.

9.5.2 Hands should be washed before and after each patient contact, if contaminated with blood or body fluids, and after

removal of gloves. If hands are not visibly soiled, an alcohol-based hand rub may be used.

9.5.3 Gloves should be used for contact with blood, all body fluids, non-intact skin, mucous membranes, and contaminated items or surfaces. They must be worn when performing venipuncture and other vascular access procedures.

9.5.4 Protective eyewear (masks, goggles, face shields) must be used if the face is likely to be splashed; for example, during procedures likely to generate droplets of blood or body fluids.

9.5.5 Fluid-resistant gowns or aprons must be used during procedures likely to splatter clothing with blood or body fluids.

9.5.6 Sharp items must be handled safely. Needles should never be recapped, bent, broken, or manipulated by hand. Place sharp items in puncture-resistant containers for disposal. Ensure that disposal containers are out of the reach of children; however, make sure they are available at points of use. Provide safety devices as appropriate.

9.5.7 Reusable sharp items should be placed in puncture-resistant containers for transport to a processing area.

9.5.8 If an environmental surface or piece of equipment is visibly contaminated with blood or body fluid, it should be cleaned with a low-level disinfectant according to manufacturer’s recommendations. After all visible blood or body fluid is removed disinfectant should be reapplied with a fresh disinfectant cloth or paper towel.

9.5.9 There should be easy access to resuscitation equipment so that mouth- to- mouth resuscitation may be avoided.

10. CONTACT PRECAUTIONS.

10.1 Rationale: Used in addition to Standard Precautions, this precaution focuses on microorganisms that may be spread by routes other than direct contact with body substances. It addresses spread of microbes through droplets or contact with contaminated environmental surfaces; examples are respiratory syncytial virus and vancomycin-resistant enterococcus.

10.2 Standards:

10.2.1 If the diagnosis is suspected prior to arrival, place the patient in a private/precaution room as soon as he or she arrives.

10.2.2 Wear gloves for any patient contact and for contact with any item that touched the patient. Remove gloves and wash hands before leaving the room.

10.2.3 Wear fluid-resistant gowns when entering the room if clothing will come in contact with the patient or if working close to the patient.

10.2.4 Wipe down all equipment that had patient contact or that is potentially contaminated with blood or body fluid with a disinfectant cleaner prior to removal from the room.

10.2.5 Post a sign on the examination or procedure room door to notify staff of the required precautions.

11. DROPLET PRECAUTIONS.

11.1 Rationale: Used in addition to Standard Precautions, this precaution is designed to reduce risk of spread through respiratory droplets larger than five microns in size (e.g., pertussis or rubella). Droplets are generated during coughing, sneezing, or talking, and during certain procedures such as bronchosocopy. Spread requires relatively close contact because these droplets do not remain suspended in the air and usually only travel about three feet or less from the individual.

11.2 Standards:

11.2.1 If the diagnosis is suspected prior to arrival, place the patient in a private/precaution room as soon as he or she arrives.

11.2.2 Post a sign on the examination or procedure room door to notify staff of the required precautions.

11.2.3 Wear a standard mask when working within three feet of the patient.

11.2.4 Place a standard mask (e.g., surgical mask) on the patient to minimize droplet dispersal if it is necessary to transport the patient.

12. AIRBORNE PRECAUTIONS:

12.1 Rationale: Used in addition to Standard Precautions, this precaution focuses on diseases spread by respiratory droplet nuclei. These small particles less than five microns in size may remain suspended in the air for long periods of time. Microorganisms spread in this manner can be inhaled by a susceptible person. Microbes spread this way include Mycobacterium tuberculosis, chicken pox (varicella-zoster virus), and measles (rubeola virus).

12.2 Specifics

12.2.1 Patients with potentially communicable diseases such as chicken pox or measles should be identified upon arrival. Identification may occur through pre-notification by phone when making an appointment, observation by a receptionist or clinical staff person, or via a sign notifying patients of the importance of communicating information.

12.2.2 Place patients known to have a disease spread by the airborne routine in a private/precaution room (room with a solid door) immediately upon arrival. The door must remain closed except during use by staff members. Ideally, the room should be at negative pressure in relation to the hall. (If practical, a fan may be placed in the window that will pull air out of the room.)

12.2.3 Post a sign on the examination or procedure room door to notify staff of the required precautions.

12.2.4 A standard mask should be worn by staff when in the same room as the patient. Persons immune to the specific illness (e.g., measles) do not need to wear a mask.

12.2.5 A N95 respirator is to be worn with all potential TB patients.

12.2.6 Make tissues available for patients. Instruct the patient to cover his or her mouth when sneezing or coughing.

12.2.7 Place a standard mask (e.g., surgical mask) on the patient to minimize droplet nuclei dispersal if it is necessary to transport the patient.

13. SPECIAL PRECAUTIONS WITH PATIENTS WITH ACTUAL OR SUSPECTED TB: See MEDDAC MEMO 40-145 (TB).

14. TUBERCULOSIS CONTROL POLICY

14.1 General. The risk of HCA infection with Mycobacterium Tuberculosis is low. Infection is most likely to occur in the Health Center when a patient has unsuspected pulmonary or laryngeal TB, has bacilli-laden sputum or respiratory secretions, and is coughing or sneezing into air that remains in circulation. The best ways to protect others from a patient with TB are to maintain a high index of suspicion for TB and to institute appropriate isolation precautions when a patient comes into the Health Center, with suspected or confirmed TB.

14.2 Employee Screening Program:

14.2.1 Military and civilian personnel are screened with a PPD test through Occupational Health when they begin employment at RWBAHC.

14.2.2 Occupational Health will annually screen all RWBACH employees (in their birth month).

14.3 Exposure of Personnel to Tuberculosis:

14.3.1 Personnel who have been exposed to patients or other personnel with active pulmonary tuberculosis will be referred to the Occupational Health Section of PMWARS.

14.3.2 The Occupational Health Nurse (OHN) will arrange for placement of a PPD skin test.

14.3.3 If positive, the OHN will refer the individual to Community Health Nurse (CHN) for a work-up

14.3.4 The OHN section will conduct the epidemiological contact surveillance for exposures in the Health Center, and the Community Health Nursing Section will conduct the exposure surveillance in the family/community.

14.3.5 Personnel with TB may work in patient care areas when the health care provider has determined that the individual is no longer infectious (usually after 2-3 weeks of drug treatment).

15. TUBERCULOSIS PREVENTION PROGRAM: see MEDDAC Memo 40-145 Tuberculosis Prevention Program

16. HAND HYGIENE TECHNIQUES

16.1 Hand washing:

16.1.1 Hand washing is considered the most important single procedure for preventing HCA infections and occupation acquired infections. Health Center personnel are believed to be the mode of transmission for most preventable HCA infections, and, in many outbreaks, hand washing of personnel have been shown to eliminate or markedly reduce hand carriage of pathogenic organisms, most of which are transient flora. Thus, it is an important means of preventing patient's exposure to pathogens that have already colonized or infected other patients.

16.1.2 Indications: When hand washing is indicated during routine patient care, a vigorous washing under a stream of water for at least 15 seconds is recommended. Technique employing friction, soap, and water is essential. As a minimum, hand washing is required:

- When coming on duty.

- After contact with a source that is likely to be contaminated with virulent microorganisms.

- When hands are visibly soiled.

- Before and after handling in-use patient care devices such as intravascular catheters, urinary closed drainage systems, and respiratory therapy equipment.

16.1.3 Technique

- Moisten hands with warm water.

- Apply soap. Use the amount recommended by the manufacturer.

- Vigorously rub all surfaces for 15 seconds, paying particular attention to areas around the finger-nails and between the fingers.
- Rinse hands thoroughly under running water to completely remove soap.

- Pat hand dry thoroughly with a disposable paper towel.

- Use the paper towel to turn off the faucet.

16.2 Antiseptic hand washing products.

16.2.1 Antimicrobial hand-wash or waterless antiseptic hand rub should be used before surgical operations or similar invasive procedures. Soap and water is adequate for hand washing between contact with individual patients, unless antiseptics are otherwise indicated.

16.2.2 Indications for use of alcohol-based hand rubs in ambulatory care include:

- Apply before each patient contact when hands are not visibly soiled. When hands are visibly soiled, use soap and water. Alcohol is not a good cleaner.

- Use of both alcohol-based hand rub and hand-washing with soap and water between patient contacts is unnecessary.

- After several applications of alcohol-based hand rubs, hands may feel sticky or gritty from the build-up of emollients and should be washed with soap and water

- After glove removal hands may feel gritty from the combination of powder and emollients and may need to be washed with soap and water.

16.2.3 Technique of application of alcohol based hand-rub.

- Apply product to palm of one hand; use the amount recommended by the manufacturer.

- Rub hand together, covering all surfaces of hands and fingers, until hands are completely dry.

16.3 Technique of surgical hand antisepsis.

- Remove rings, watches, and bracelets.

- Thoroughly wash hands and forearms with plain soap, under running water, before the first surgery of the day, including use of nail cleaner.

- When using antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually two to six minutes, followed by rinsing and drying with sterile towels.

- When using an alcohol-based hand rub, follow the manufacturer’s instructions for quantity and application method. Allow hands and forearms to dry completely before donning sterile gloves.

- Apply sterile gloves in a manner to prevent recontamination.

- NO USE OF ARTIFICIAL NAILS OR NAIL POLISH PERMITTED IN THE OR SUITES.

17. APPROVED DISINFECTANTS

17.1 The products should be evaluated and exhibit several characteristics to include broad antimicrobial spectrum, contact time, cost, and stability.

17.2 The following is a list of disinfectants approved by the Infection Control Committee for use in the Health Care Center. in patient care areas (does not include Housekeeping's list).

TYPE	USE
Asepticare	Aerosol
Staphene	Aerosol
Acute Kare	Skin
Betadine (scrub, solution	Skin
Kindest Care	Skin
Phisohex	Skin
Dynahex (Hibiclens)	Skin
Alcare (foam alcohol scrub)	Skin
70% Ethyl Alcohol (solution or pads)	Skin
S State Hand Sanitizer w/Aloe	Skin
Hydrogen Peroxide	Irrigations
Peracetic Acid	Steris System Instruments
Klenzme	Instruments
Sonic Detergent	Instruments
Bleach	Surfaces/Instruments
Bleach (Pure Bright)	Surfaces
Carex Antiseptic	Surfaces
D-STROY	Surfaces
Formula 409	Surfaces
LPH	Surfaces
Taski TR 163	Surfaces
Tile Brite Cleaner	Surfaces
Ultra Lime-a-way	Surfaces
Wex-cide	Surfaces
Cavicide	Surfaces
Purrell Hand Sanitizer	Skin
A464N/50ON	Toilets and Drains
Urinal-Ade	Toilets
CIDEX OPA	Endoscopes

18. STERILE SUPPLIES:

18.1 General: In order to provide sterile processing of medical/surgical instruments, this section establishes guidelines for all departments/clinics requiring the services provided by Central Materiel Services (CMS).

18.2 Responsibilities:

18.2.1 CMS Services: Will provide sterilization services to all Clinics requiring this service.

18.2.2 Department Chiefs/OIC's/NCOIC's of Clinics will: Request needed services; ensure that all instruments turned in to CMS for sterile processing have been decontaminated and are free of debris; ensure that instruments are brought to CMS in a closed/covered container; Be accountable for instruments and supplies; and ensure that rotation of sterile supplies is accomplished routinely to prevent outdates.

18.3 Operating Rules:

18.3.1 Prepackaged sterile items are considered sterile until opened or damaged. Packaging shall be inspected prior to use.

18.3.2 All requested instruments, sets, and supplies will be submitted to CMS between 0700-1400 Monday, Tuesday, Wednesday, and Friday. This turn-in ensures timely processing and return of all sterilized items.

18.3.3 Personnel will turn-in items to a CMS technician in person. The unit turning in instruments/sets will complete an inventory of instruments/sets turned in on DA Form 3750, Centralized Materiel Service Item Request and Issue (Encl 1)in duplicate. At the time of the turn-in, the CMS technician will inventory instruments/supplies and conduct a cleanliness inspection.

18.3.4 CMS will not accept any instruments/supplies that contain blood, body fluids, or tissue. Instruments must be cleaned thoroughly before being sterilized. Cleaning includes physical removal of soil, blood, tissue, or other organic matter with instrument detergent, mechanical action (brushing), and rinsing. Cleaning removes the debris, reduces the quantity of microorganisms, and renders the item safe to handle.

18.3.5 CMS provides STEAM, STERIS, and STERRAD sterilization. Ethylene Oxide is not used at this facility.

18.3.6 Accountability of instruments/supplies:

18.3.7 Only complete sets will be accepted, unless noted on the turn-in slip.

18.3.8 The originating unit is responsible for the replacement of any missing instruments/supplies.

18.3.9 Any damaged or worn instruments will be replaced by the clinic.

18.3.10 All supplies and instruments issued by CMS will be wrapped or peel packed. These items must be kept in a closed cabinet or drawer to provide an event related shelf life. If the integrity of the seal is compromised, the item shall be returned to CMS for reprocessing. Clinic supervisors shall ensure that sterile supplies are stored in areas that would preclude damage to the wrapping or integrity of the seal. Processed sterile instrument packs or prepackaged supplies will be stored on shelving 8 to 10 inches from the floor and at least 18 inches from the ceiling sprinklers.

18.3.11 All CMS sterilized items will have a 3M Attest Rapid Readout Biological Indicator each day. NOTHING Will be released from CMS until the biological indicator results are read (maximum time -is 3 hours) and the desired results are negative.

18.4 WRAPPING PROCEDURE: All items-used in sterile procedures are to be wrapped using one of the following methods.

18.4.1 Peel Pak Wrappers.

- Supplies placed in peel packs and sealed are considered sterile unless the integrity of the packaging has been compromised (i.e., torn, wet, etc.).

- Double peel packs are not required, but may be used for convenience in handling. Both will be sealed.

- All sharp tipped or delicate items must be protected from damage when being wrapped with this method.

18.4.2 Non-woven paper, plastic paper laminate. Supplies double wrapped in paper (nonwoven) are considered to have event related shelf life (sterility).

18.5 Commercially prepared sterile items: Commercially prepared sterile items will be considered sterile unless the integrity of the packaging has been compromised or the manufacturing expiration date has been reached. Commercially sterilized (prepared) items intended for one time use will not be re-sterilized.

18.6 If uncertain as to the suitability of a product, consult the Infection Control nurse or CMS for information and guidance.

18.7 Storage of Sterile Supplies: Sterile supplies in clinics will be kept in a closed cabinet. They will also be rotated. Clean items should be stored separately from sterile items. Area must be clean, dry, dust-free, and lint-free. Temperature should be 65F-72F. Items will need to be stored off the floor to prevent contamination (i.e., mopping, wet-vacuuming)and in addition, 18 inches from the ceiling Sprinklers.

19. CLEANING OF INSTRUMENTS: Instruments must be cleaned thoroughly before being sterilized. Cleaning includes physical removal of soil, blood, tissue, or other organic matter with instrument detergent, mechanical action, and rinsing. Cleaning removes the debris, reduces the quantity of microorganisms, and renders the item safe to handle. Enzymatic instrument detergent, diluted according to label instructions, should be used for cleaning. Enzymatic detergents do not contain germicides, but do effectively remove organic matter.

20. REUSE OF DISPOSABLE SINGLE USE DEVICES

20.1 Single Use Devices(SUDs). Disposable equipment and supplies that are designated for single patient use are to be used once and discarded according to the manufacturer’s directions.

21. THERMOMETERS.

21.1 General: Glass thermometers will be used only when an electronic thermometer or a disposable thermometer is not Available; if their use is specifically ordered by a PCM and/or with isolation precautions. Electronic thermometers may be used in isolation if the machine remains in the room for the duration of the isolation and is cleaned thoroughly with LPH, Cavicide, or approved disinfectant when isolation is discontinued. Probe covers for the electronic units are procured by the NCOIC of the clinic.

21.2 Electronic Thermometers:

21.2.1 Measuring Fever By Electronic Thermometer: Electronic thermometers that are designed to be used orally (in the mouth) or rectally are an acceptable alternative to a glass thermometer and take a temperature more quickly. They are, however, more expensive than the glass alternative. Strips that measure temperature on the forehead are not accurate and should not be used. After use, all thermometers will be cleaned with an approved disinfectant. Staff members will wash hands after performing rectal temperatures.

21.2.2 IVAC Electronic Thermometers: Remove the electronic thermometer from the charger. Grasp the probe at the base end. Withdraw the probe from the storage well and insert it into the disposable probe cover. Press down to secure the probe cover in position. Carefully slide probe under the patient's tongue, if oral probe is used. If rectal probe is used, lubricate and gently insert probe tip one inch into anus carefully. Keep eyes on position of the probe. An audible signal will indicate when correct temperature is taken. Remove probe. Discard probe cover in waste receptacle by pushing release button at base of probe. Read and record thermometer. Return probe to storage well. This will automatically erase the temperature recorded and will turn off the thermometer. The electronic thermometer should also be returned to charging base immediately when not in use. Cleaning of the electronic thermometer should be performed daily, and if contaminated, using a damp cloth and a hospital approved disinfectant/detergent.

21.2.3 Tympanic Genius Electronic Thermometer: Remove probe from the base unit. Select TYMPANIC by pressing MODE button (if TYMPANIC not already displayed). Place disposable cover on probe tip. Place probe in ear canal and seal opening. With infant, press probe gently over opening to seal. Press and hold SCAN button. Remove probe from ear as soon as triple beep is heard and display reads DONE. Press blue RELEASE button to discard disposable cover directly into waste receptacle. Return probe to base unit. Press and hold MODE button to change Fahrenheit to centigrade. Unit is cleaned daily and whenever contaminated by wiping the unit with LPH, Cavicide, or approved disinfectant.

21.2.4 Critikon Dinamap Model 8100T Electronic Thermometer: Obtain a blue temperature probe assembly and apply probe cover. Connect temperature probe to front panel probe connector. Use a red temperature probe for rectal temperatures. Blue and red probes are NOT interchangeable.

21.3 Oral temperatures: Insert the probe under the tongue into the right or left sublingual pocket. Hold the probe steady until determination is complete. After the determination is complete, remove the probe and discard the probe cover by pressing the button on the probe handle. Place the probe into the probe holder.

21.4 Rectal Temperatures: A standard glass and mercury thermometer should be left in place for a minimum of 3 minutes. Make sure to shake down the thermometer before using it. Appropriate care should be taken in inserting, maintaining and withdrawing the rectal thermometer. To take a rectal temperature safely, place the child prone (stomach side down) on a firm surface. After separating the buttocks, insert a lubricated thermometer approximately 1 inch into the rectum. After at least 3 minutes, remove the thermometer. A rectal temperature will read approximately one degree higher than a simultaneously obtained oral temperature.

21.5 Glass Thermometers: obtain thermometer and appropriate storage tray from CMS. Return to CMS for cleaning daily as a one-for-one exchange. Remember to only use oral thermometers in the mouth or axilla, and only rectal thermometers in the anus.

22. REFRIGERATOR/ICE MACHINES

22.1 General: Proper cleaning and use of ice machines, ice scoops and refrigerators will decrease bacterial contamination of ice machines, ice scoops, and refrigerators, thereby reducing bacterial transmission to patients and staff.

22.2 Ice Machines

22.2.1 Location: low traffic areas preclude contamination from splashing liquids. Do not store equipment on top of or inside ice machine. Information sign prominently displayed on ice machine stating “Staff Only- Wash hands before use”.

22.2.2 Scoops: Scoops are cleaned on a daily basis with detergent/germicide or hypochlorite (bleach) solution of approximately 50ppm (3cc hypochlorite to 1 gallon of water) and rinsed thoroughly. Place the scoop in a clean, uncovered container such as a clean tray or pan when not in use. Clean and date ice scoop container as well.

22.2.3 Cleaning of bin-type ice machines. On a weekly basis, ice machines will be externally cleaned with detergent/germicide. On a monthly basis, disconnect machine, empty the bin and let it thaw. Using disposable cloths, clean all internal surfaces with soap and water solution giving special attention to cracks, crevices, and recesses. Rinse well with water then wipe off with bleach solution (3cc per 1 gallon of water). Allow to dry and reconnect machine. Document cleaning on the universal cleaning chart. Check manufacturer's recommendation for servicing.

22.2.4 Cleaning of dispenser-type ice machines. On a daily basis, wash all exterior parts of the machine and all parts that are easily detachable (drain rack funnel) with soap and water solution. Every three months the machine will be disassembled, cleaned and disinfected by the refrigerator engineers. Record daily and quarterly cleaning on the universal cleaning chart form.

22.3 Refrigerators

22.3.1 Medication Refrigerators: Record daily temperatures and weekly cleanings. Temperatures should remain between 35-40 degrees Fahrenheit or 2 degrees to 4.5 degrees Celcius. Notification of the Infection Control provider, Department NCOIC, and Deputy Chief Health Services (DCHS) will be provided if the refrigerator alarm system fails.

22.3.2 Staff Food Refrigerators: Do not need daily temperature recordings, but do need to be cleaned WEEKLY with a detergent/ germicide. All open/unlabeled food items will be disposed of weekly by the close of business on Friday. Record weekly cleaning.

22.3.3 List on a DA 4106, corrective actions taken when temperature is out of range or a power failure occurs: OIC/ NCOIC will notify Biomedical Maintenance and Pharmacy when medications have been affected.

22.3.4 Possible mechanisms to ensure that Medication Refrigerators not on an alarm system have had a power failure: a clock plugged into the same wall outlet as the refrigerator, if the clock is off time it would indicate power failure; a penny placed on top a cup of frozen water, placed in the freezer. If the penny is submerged in the cup, it is a good indication that the refrigeration is not working properly.

23. TERMINAL CLEANING OF PATIENT CARE AREAS

23.1 A designated housekeeper Mon-Fri is responsible for cleaning Clinics during day and evening shifts. If a housekeeper is not available the clinic staff will perform the task. Clean equipment/supplies will be stored in a “clean” utility room and dirty equipment/supplies will be stored in a “dirty/soiled” utility room.

23.2 Clinic staff are responsible for cleaning the entire exam room between each patient, to include but not limited to the table/gurney(s)/beds , stands, blood pressure cuffs and all other equipment touched by the patient, (All exam rooms will be cleaned with cavicide.) and for replacing curtains.

23.3 Housekeeping Personnel are responsible for cleaning floors and bathrooms daily. Walls, windowsills, air vents, lamps, and lockers as necessary.

23.4 Remove linen/paper from the bed by folding it upon itself making sure that non-linen items are not included in the linen bundle. If any of the linen is wet, ensure that the wet portion is located in the center of the bundle. Keep linens away from your uniform.

23.5 Cleaning will be accomplished in a top to bottom manner, cleaning highest surfaces first. Low level disinfectants are adequate for environment surface cleaning. According to Association for Professionals in Infection Control (APIC), “the most commonly used and best cleaners are quaternary ammonium compounds". Because of the importance of mechanical cleaning, a product containing detergents or surfactants should be selected. Cleaner disinfectants must be diluted, used and stored exactly as the label instructs.

23.6 Precaution Room – see para 12.2.2 Wear appropriate PPE. Precaution room to be cleaned as above unless person or persons are suspected to be infected with TB. (This room is not to be used for patients with known TB). **For Tuberculocidal activity surfaces must remain wet for a full 5 minutes. Wipe surface using a towel or allow to air dry.

24. CLEANING UP BODY FLUIDS

24.1 General: Cleaning up spills of any fluid must be done in a timely manner to prevent not only exposure to contagious fluids but also to prevent falls. Wet floor signs should be used in the immediate area of a spill on the floor until the floor is dry. If the origin of the spill is unknown, clean up must be done as described in the following procedure for cleaning blood and body fluids from all surfaces. Heavy vinyl gloves should be worn for all cleaning procedures. If unavailable, double glove with the latex gloves. Be sure to disinfect the heavy vinyl gloves after each use.

24.2 Simple/small spill (no sharp material in fluid): Using a disposable absorbent material (paper towels, paper wash cloths, chux) wipe up the spill. Place the wipe material in a red trash bag. Flood area with LPH or a diluted bleach solution. Ensure that the spill area remains wet with the disinfectant for a minimum of (10) ten minutes.

24.3 Simple/large spill (no sharp material in fluid) If the spill area is too large to soak up with paper products, a mop may be used. Take care not to extend the edges of the spill any further than necessary. The mop head must be disposed of in a red trash bag. Flood the entire area with LPH or a diluted bleach solution. Ensure that the spill area remains wet with the disinfectant a minimum of (10) minutes.

24.4 Spill with glass or other sharp materials. UNDER NO CIRCUMSTANCES should a spill with glass be cleaned up in either of the first two methods of this procedure. Use an Emergency Spill kit for blood and body fluids. Follow the instructions inside the kit. Do not use a spill kit for chemicals. If a spill kit is not available use a pair of forceps to pick up the pieces of glass or use 2 pieces of stiff cardboard to scoop the sharp pieces in a dustpan fashion. The cardboard is disposed in

a red trash bag. Forceps will be disinfected and sent to CMS for sterilization. Place the pieces of glass in a sharps container. When all the glass is removed, soak up the fluid portion with a disposable but absorbent material, dispose in a red trash bag, and flood the area with LPH or a bleach solution. Ensure that the spill area remains wet with the disinfectant a minimum of (10) minutes.

25. DISPOSAL OF WASTE

25.1 General: Special care must be taken in the methods of disposal to ensure that contamination of personnel, patients, and the immediate environment do not occur. Waste will be processed as follows:

25.2 Administrative Area. No special handling required.

25.3 Service Areas. Waste from these areas include; cartons, packing materials, glass bottles, cans, and rags. These items can create a hazard in the form of physical injury. Containerize and transport to prevent personnel injury.

25.4 Patient-Care Areas. Waste should be containerized at the point of generation. Waste generated in the exam rooms, with the exception of needles, syringes, and other sharp objects should be placed in a durable plastic bag and sealed with tape and transported to the dirty utility room. Waste that has made contact with patient body fluids, excretions and/or blood shall be considered contaminated. Contaminated waste will be placed in the contaminated waste container. The contaminated waste container will consist of one red bag (4ml thickness) that meets specification IAW 40 Code of Federal Regulations.

26. MULTI-DOSE VIALS

25.1 General: Special care must be taken in the methods of disposal to ensure that contamination of the medication does not occur.

26.2 Unopened multi-dose vials will expire on the manufacturer's expiration date, or when obvious contamination occurs, i.e. cloudiness or floating particles are detected. Open Vials must be dated and initialed by the person opening the vial and discarded in 28 days.

26.3 Oral medications will be considered to be expired upon reaching the manufacturer's labeled expiration date. If the solution is known to have been inadvertently contaminated, appears contaminated on visual inspection or the medication has not been stored according to manufacturer's recommendations this solution is considered expired and must be discarded.

26.4 Containers of medications labeled "single dose" or single dose vial or those packaged in break tip ampules are not multidose vials. Once they have been opened and a dose removed they will not be used for subsequent doses.

26.5 Sterile solutions used for invasive irrigation (e.g. normal saline, sterile water in surgical irritations) will not be recapped and reused as recapping renders the solution unsterile.

27. VISITOR POLICY

27.1 General: The purpose of a visitor policy and traffic control is to provide, "Patient Visiting Information", specifically in relation to precautions for the control of health-acquired/health associated infections, and thus assists in ensuring the safety and health of patients, visitors, and personnel.

27.2 Any person (adult or child) demonstrating signs of upper respiratory illness or other communicable disease should be restricted. Clinics may provide masks as necessary to patients.

27.3 Special areas:

27.3.1 Recovery Room and Operating Room - The doors to these units must be closed at all times. Personnel may not proceed beyond the Red Line of the Operating Room without proper "scrub" attire to include scrub cap, and shoe covers (if wearing outside shoes). See Operating Room SOP for Infection Control measures.

27.3.2 Pediatrics - Parents of pediatric patients, when indicated, may be permitted to remain in the recovery area with the child.

28. VENDING MACHINES

28.1 All food items placed in the vending machines in R. W. Bliss Army Health Center (to include outlying clinics) will be individually packaged.

28.2 No hot food(s) or potentially hazardous food(s) (e.g. dairy products) will be placed in the vending machines. Refrigerated items must be kept refrigerated.

28.3 The vendor will remove outdated items during restocking.

28.4 Quarterly, the vendor will wash the dispensing portions of the machine with soap and water.

29. COLLECTION AND HANDLING OF LINEN

29.1 General: Although linen has not been linked to the acquisition of infection (with the exception of lice and scabies), it still needs to be handled in such a manner that clean linen remains clean and soiled or potentially contaminated linen does not add to the microbial load in the environment.

29.2 Clean linen - includes all linen which has been processed by the laundry using approved methods and has been through the transfer/receiving process in a manner to minimize contamination by the environment/personnel. Clean linen will:

29.2.1 Be handled as little as possible.

29.2.2 Be stored in an enclosed room, in a covered receptacle, on a covered cart, on covered shelves, in covered bins, drawers, or linen closets. The protective cover must, however, be in place (down) at all times. All linen storage carts must have a solid bottom for the protection of clean linen.

29.2.3 Be stored away from direct patient care areas.

29.2.4 Always be transported in clean linen receptacles.

29.3 Dirty/Soiled linen - will be placed in a clear plastic bag except as noted below.

29.4 Infectious linen - includes linen, which is contaminated with the patient's body fluids, blood, secretions, or excretions. The following areas will utilize the yellow linen

bags: PACU, OR, and the Specialty Clinic. All other clinics will use a clear bag to store dirty/soiled linen. However, if a clinic does generate infectious linen then it will utilize the yellow linen bag. All infectious linen will:

29.4.1 Be collected in yellow bags at the point of generation.

29.4.2 Be stored in a covered bag/container.

29.4.3 Be held and carried away from the body.

29.4.4 Not be sorted, counted or presoaked.

29.5 Personnel will wash their hands prior to and following contact with all linen. Vinyl gloves will be worn when handling infectious linen.

29.6 If any leakage occurs from the linen bag, place the bag and its contents into another bag.

30. ELECTRIC RAZORS. No common use razors will be utilized at RWBAHC. Disposable razors or clippers are the only acceptable shaving instrument that will be used in this facility.

31. TOYS. Soft toys should not be provided. Toys should be restricted to those easily cleaned. Books and puzzles seem to pose little risk and need not be cleaned unless visibly soiled. Frequency of routine toy cleaning may be daily to weekly depending on intensity of use. Flowering plants should not be in exam rooms or offices where patients with allergies may be seen.

32. SAFETY SYRINGES.

32.1 General: In order to provide safety for our staff and patients, a safety syringe system will be utilized in all clinical areas at RWBACH and outlying clinics. The implementation of this system is designed to reduce needlestick exposures.

32.2 All procedures that require a syringe and needle will utilize a safety syringe.

32.3 If it is impossible to utilize a safety syringe as a result of the procedure or if the safety syringe doesn't come in the proper gauge, then it will be permissible to use a standard syringe needle (Please ensure that you have cleared this with Infection Control and/or Patient Safety) prior to use of non-safety items.

32.4 All staff will be trained on the correct utilization of the safety syringe.

32.5 After use, the safety syringe will be discarded in a sharps container.

33. ASEPTIC TECHNIQUE

33.1 General: Asepsis is the absence of disease-producing organisms. Aseptic techniques are those practices which help to reduce the transmission of pathogenic organisms from one person or place to another. Aseptic techniques are necessary to prevent contamination of wounds, to isolate the site to be worked on from the rest of the body, to create a sterile field for sterile procedures, and to protect staff, patients, and visitors from needless risk of infection.

33.2 Keep patient care areas clean. Staff will not consume (eat) food of any kind in patient care areas.

33.3 Keep all contaminated material (e.g., soiled linen, dirty dressings, or excretions)away from one's own body. Always wash hands after coming in contact with such items.

33.4 Wash hands or use hand rub prior to any contact with sterile items. Keep hands in sight and above waist level.

33.5 Put on sterile gloves (gown as required by procedure).

33.6 Sterile equipment should be handled only with sterile gloves or other sterile equipment.

33.7 Establish a sterile field when doing procedures (e.g., suturing of lacerations, dressing changes, wound irrigations), which require asepsis. All trays and sets should have an inner wrapper, sterile towel, or drapes that can be used for this purpose; if not, use disposable sterile towels (available in CMS).

33.8 Prepare the sterile field immediately prior to use. An unattended sterile field and long exposure to air increase the possibility of contamination.

33.9 Keep the sterile field, and sterile supplies, in view at all times. This helps prevent accidental contamination from an outside sources. Never turn your back to a sterile field.

33.10 Keep sterile items separated from non-sterile items. Establish an area away from the sterile field for waste.

33.11 Remember when opening sterile items, both wrappers are opened. The inside of the package must not be touched by any unsterile object, otherwise the sterile object is contaminated.

33.12 The edges of the inside wrappers of sterile supplies are not sterile once a package has been opened.

33.13 Only the top of the sterile field is considered sterile. DO NOT reach across the sterile field. Never pass an unsterile item across a sterile field. Keep the area dry. Moisture will contaminate the field.

33.14 Avoid excessive movement around a sterile field, as this increases air movement.

33.15 Stay at least one foot away from a sterile field.

33.16 If there is any doubt as to the sterility of an item, DO NOT use it. The following are reasons for rejecting an item.

33.16.1 If it has fallen on the floor (even if still in the original packaging).

33.16.2 It is, or shows signs of having been wet or is damp/wet.

33.16.3 If there are holes, tears, or any breaks in the wrapper, or if the seal on the packaging permits outside air into the package.

33.16.4 If the sterilization expiration date has passed (always check the expiration date on a sterile item before using it).

33.16.5 If either the external sterilizing tape or the internal indicator have not changed to the appropriate color.

34. COLLECTION OF URINE SAMPLES.

34.1 General: Proper collection and handling of urine samples are essential in obtaining accurate laboratory results. Improper technique and delay in transport of the specimen to the laboratory could alter vital diagnostic information. If a culture is ordered by a provider, be sure the urine sample is collected in a sterile container.

34.2 Clean Catch or Midstream Urine Specimens:

34.2.1 MALES - Recent studies have indicated some contamination of urine specimens by males who had not cleansed the urethral meatus. Therefore, in obtaining a clean catch urine specimen the male should be instructed to:

34.2.1.1 Not touch the inside of the cap or container with anything other than urine.

34.2.1.2 Hold foreskin back with one hand, cleanse the urethral meatus, begin to urinate and place the sterile cup under the stream after the flow of urine has commenced.

34.2.1.3 After at least one fourth of the cup has been filled, the cup should be secured and any spilled urine on the outside of the container cleaned.

34.2.2 FEMALES - Females should be instructed to wash the urethral meatus prior to obtaining a midstream specimen. Provide the patient with two prepackaged cleansing wipes (i.e., "Castile Soap Towelettes") and instruct her to do the following:

34.2.2.1 With 2 fingers hold the outer folds of her vagina away from the opening through which she urinates.

34.2.2.2 Wipe the opening from front to back with the cleansing wipe(s) twice, begin to urinate and place the sterile cup under the stream after the flow has commenced.

34.2.2.3 After at least one fourth of the cup has been filled, the cap should be secured and any spilled urine on the outside of the container cleaned.

34.2.2.4 If no prepackaged cleansing wipe is available, soap and water should be used to clean the urethral meatus. Provide the patient with four sterile gauzes, a sterile specimen cup and liquid soap. Instruct the patient to prepare the sterile gauze as follows: 1 gauze with soap and water, 2 gauze with water, 1 dry gauze.

34.2.2.5 Using the technique described previously have the patient wipe the urethral meatus with the soapy gauze, dispose of the gauze in the waste basket, then wipe once with each of the moistened gauzes. Last of all, dry the area with the dry gauze. Instruct the patient to always wipe from front to back.

34.3 Catheterization Urine Sample - In and Out Cath – (This Procedure is performed only in the Pediatric Clinic) This specimen should be obtained using strict aseptic technique. The following procedure is recommended:

34.3.1 Orient patient/parent to procedure.

34.3.2 Prepare sterile field with a #5 or #8 Feeding Tube, specimen cup and betadine swabs. Also have a container available for the excess urine.

34.3.3 Position patient – Male or Female, supine with hips flexed and outwardly rotated, knees flexed, and feet together.

34.3.4 Wipe urethral meatus with 3 betadine swabs. (Females from front to back).

34.3.5 Insert the appropriate Feeding Tube, ensuring it does not become contaminated.

34.3.6 Collect the urine in the sterile specimen cup to at least one fourth of the way and allow the rest of the urine to flow in a separate container.

34.3.7 Gently remove the feeding tube when the urine has stopped flowing and give the patient/parent a moistened gauze to wipe off the betadine.

34.3.8 Place the cap securely on the container

34.4 Once the urine sample is obtained it should be transported to the laboratory immediately. Only in extreme cases of staff shortage should the specimen be allowed to remain in the area of collection. If there must be a delay in transport to the laboratory, the urine sample should be refrigerated.

35. ACCIDENTAL NEEDLE STICK/SHARPS, INJURY, OR SPLASHING

35.1 SELF AID: The injured employee with an accidental parental (e.g., needle stick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluid will complete the self aid process immediately following the injury and prior to any other activity.

35.1.1 Bleed the area, if skin is broken to flush the wound of any contamination. Wash the area with an approved bactericidal solution. For splashing into the eyes, flush with water only.

35.2 REPORTING: The injured employee will report the injury/incident promptly to the immediate supervisor (OIC/NCOIC).

35.2.1 Supervisors will complete the following forms for their employees: Military Employees: MEDCOM Form 754-R, Record of Injury and a DA Form 4106 (Incident Report). Civilian Employees: MEDCOM Form 754-R, Record of Injury, CA-1, Federal Employees Notice of Traumatic Injury and Claim, and a DA Form 4106 (Incident Report).

35.2.2 To facilitate the time requirements of the CDC, baseline blood work may be ordered by a Healthcare provider in the clinical area where the employee is working. The injured employee needs the following items when reporting to the Internal Medicine Clinic for medical evaluation: Military: Medical records (if available) and completed MEDCOM Form 754-R, (this form is to be taken directly to the Safety Officer by the safety NCO),the social security number of the "source" patient (if known); Civilian: Completed MEDCOM Form 754-R,(this form is to be taken to the Safety Officer by the safety NCO), completed CA-1 (items 17-38), and the name and social security number of the "source" patient (if) known.

35.2.3 The injured employee must report to Internal Medicine Clinic immediately(0800-1400), if no internist is available report to Primary Care Manager (PCM) or Deputy Commander

Clinical Services (DCCS). Follow up and counseling will be done in Occupational Health. The injured employee must report to Occupational Health after Protocol has begun.

35.3 SOURCE PATIENT: should be identified and his/her name sent to the internist treating the victim. The source patient should have blood drawn for HIV, and hepatitis A, B, and C.

35.4 VICTIM:

35.4.1 Military: HIV, Hepatitis B, and, C Panel, Liver Enzymes and Renal Panel will be drawn.

35.4.2 Civilians: Will be given an option and refusal will be documented in employee's medical record.

35.4.3 Lab slips should be labeled Occupational Health to ensure that the results are reported to Occupational Health for enclosure in the injured employee's record. If results are positive, Occupational Health will notify the attending physician of the "source" patient.

35.5 TREATMENT OF THE INJURED EMPLOYEE: Internal Medicine physician will evaluate and treat the injured employee. All treatment and follow up will be CONFIDENTIAL.

35.5.1 HIV and Hepatitis A, B, and, C Panel will be performed and results forwarded to Occupational Health.

35.5.2 HBIG or Human Serum Globulin (ISG) and tetanus toxoid will be administered if indicated.

35.5.3 The following forms will be completed: Military: MEDCOM Form 754-R and DA 4106, and documented in medical records. Civilian: MEDCOM Form 754-R, CA-1, and a DA Form 4106 and documented in civilian medical records.

35.5.4 Internal Medicine Clinic Supervisor/Charge Nurse or DCCS will ensure forms are completed and forwarded to the Occupational Health Section.

35.5.5 Occupational Health will determine the need for Hepatitis vaccination or follow up.

35.6 FOLLOW UP:

35.6.1 Occupational Health will maintain the employee's records and will conduct the follow up testing.

35.6.2 HIV testing will be conducted at 3, 6, and 12 months from date of injury.

35.6.3 The injured individual and the Healthcare Provider will be responsible for obtaining the HIV test and ensuring results are forwarded to Occupational Health.

35.6.4 Occupational Health nurse will remind individuals of the follow up dates.

35.7 Treatment of Post-Exposure: It should be recognized that the incidence of HIV positivity in our patient population is extremely low and prophylactic treatment will be necessary only for a short time until the HIV status of the source patient is established by a blood test. The guidelines below assume that the source patient is positive, an assumption we have to make until we are sure the source is negative. The U.S. Department of Health and Human Services CDC recommendations from 2000 are as follows. (see below). For additional information contact the CDC at 1 800 448-4911.

Evaluate Risk of Percutaneous Exposure

Highest Risk:	Increased Risk:	No Increased Risk:
BOTH larger volume of blood (e.g., deep injury, large-diameter needle previously in source patient's vein or artery) AND high titer of HIV (e.g., source patient with acute retroviral illness or end-stage AIDS)	EITHER larger volume of blood OR high titer of HIV	*No* larger volume of blood *No* high titer of HIV (e.g., injury with a solid suture needle from source patient with asymptomatic HIV)

Summary of PHS Recommendations for PEP

Exposure Type: PERCUTANEOUS

Source	Prophylaxis	Regimen
Blood- Highest Risk	Recommend	ZDV (200mg tid) + 3TC (150mg tid) + IDV (800mg tid, i.e., q8h)
Blood- Increased Risk	Recommend	ZDV (200mg tid) + 3TC (150mg tid) +/- IDV (800mg tid, i.e., q8h)
Blood- No Increased Risk	Offer	ZDV (200mg tid) + 3TC (150mg tid)
Fluid containing visible blood, other potentially infectious fluid, or tissue	Don't offer	

Exposure Type: MUCOUS MEMBRANE

Source	Prophylaxis	Regimen
Blood	Offer	ZDV (200mg tid) + 3TC (150mg tid) +/- IDV (800mg tid, i.e., q8h)
Fluid containing visible blood, other potentially infectious fluid, or tissue	Offer	ZDV (200mg tid) +/- 3TC (150mg tid)
Other body fluid (e.g., urine)	Don't offer	

Exposure Type: SKIN-INCREASED RISK (e.g., exposure to high titer of HIV prolonged contact, extensive area involved, or skin is visibly compromised)

Source	Prophylaxis	Regimen
Blood	Offer	ZDV (200mg tid) + 3TC (150mg tid) +/- IDV (800mg tid, i.e., q8h)
Fluid containing visible blood, other potentially infectious fluid, or tissue	Offer	ZDV (200mg tid) +/- 3TC (150 mg tid)
Other body fluid (e.g., urine)	Don't offer	

If PEP is offered, the recommended course

The proponent agency of this publication is the Deputy Commander for Clinical Services. Users are invited to send comments and/or suggested improvements to Commander, USAMEDDAC, ATTN: MCXJ-CCS, Fort Huachuca, AZ 85613-7079.

FOR THE COMMANDER

OFFICIAL:

GREGORY A. SWANSON
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Deputy Commander for
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Information Management Officer

DISTRIBUTION: A

APPENDIX A: STATEMENT OF AUTHORITY

MCXJ-CDR DATE

STATEMENT OF AUTHORITY

The Infection Control Committee, the Chairman of the Infection Control Committee/Infection Control Officer have the authority to institute any appropriate infection control measures deemed necessary to protect patients and/or personnel from communicable disease.

Deputy Commander Clinical Services
SIGNATURE BLOCK

COMMANDER'S
SIGNATURE BLOCK

APPENDIX B
INFECTION CONTROL OFFICER PERFORMANCE STANDARDS/JOB DESCRIPTION

1. PURPOSE: To establish guidelines for the role of the Infection Control Officer at RWBAHC, Ft. Huachuca, AZ and to delineate areas of responsibility and major functional duties.

2. SCOPE: This clinical guideline applies to the Infection Control Officer assigned to the RWBAHC, FT.Huachuca, AZ.

3. RESPONSIBILITY: The Infection Control Officer is responsible to the Deputy Commander for Health Services (DCHS); Deputy Commander for Clinical Services; the Chairman Infection Control Committee (if different from the Infection Control Officer); and the Health Center Commander

4. REFERENCES:

4.1 Friedman, C., Petersen, K.H., Infection Control in Ambulatory Care. (2004). Jones and Bartlett Publishers, 40 Tall Pine Drive, Studbury, MA 01776.

4.2 Joint Commission on Accreditation of Healthcare Organizations, Standards for Ambulatory Care (2005). Joint Commission Resources, One Renaissance Blvd. Oakbrook Terrace, IL 60181.

4.3 Center for Disease Control. www.cdc.gov.

5. GENERAL: The position of Infection Control Officer involves multiple roles and duties:

5.1 An Infection Control Professional with the specialized training assists in preventing the occurrence or transmission of infectious diseases in patients' and staff through education, consultation, surveillance and research. The ICP meets certain minimum qualifications to enter the profession.

5.2 Performs surveillance for infections:

5.2.1 Infection and control practice that is specific to the practice setting, population served, and the continuum of care.

5.2.2 Epidemiology: Institutes, maintains and evaluates records and data pertinent to all surveillance and monitoring programs. This method includes principles and statistical methods, including risk stratification, to identify target populations, analyze trends and risk factors, and design and evaluate prevention and control strategies.

5.3 Provides education for infection prevention and control and healthcare epidemiology.

5.3.1 Provides orientation and annual training in infection control for Health Center employees to include active duty, civilians, reserves and volunteers.

5.3.2 Provides resource information and/or materials to units, departments or services requesting infection control prevention education.

5.3.3 Provides education for the prevention of infections as required through the results of surveillance activities and/or federal/state/local requirements (to include OSHA).

5.3.4 Attends infection control conferences concerning surveillance, prevention and control in ambulatory care and disseminates pertinent information.

5.3.5 Reviews the current periodic literature for substantiation to recommendations concerning the prevention and control of ambulatory care acquired infections.

5.4 Provides consultation and expert knowledge and guidance in epidemiology and infection prevention and control-related issues.

5.4.1 Serves as an active participant on various committees to suggest revisions of Health Center procedures and techniques concerning infection control (substantiating recommendations): Infection Control Committee; Safety Committee; Nursing Administrative Guidelines and Standardization; Linen Advisory Board; Material Standardization Committee; Nursing Executive Committee.

5.4.2 Advises and supervises personnel on Health Center isolation policies. Implements the appropriate management of problems, which may be of an infectious nature.

5.4.3 Maintains close communications with all supervisors, head nurses, nurse clinicians and health care providers through meetings or rounds. This will ensure that the Infection Control Officer is the primary focal point to which information will accumulate in regard to patients being treated in the Health Center with possible communicable diseases and to those who may have HCA infections.

5.4.4 Reviews environmental cleanliness through routine observation.

5.4.5 Serves as consultant on infection control problems related to all clinical areas. Detects evidence of cross infection and assists in the development and/or implementation of improved infection control measures.

5.4.6 Conducts an annual review of cleaning procedures, agents and schedules in use throughout RWBAHC.

5.4.7 Serves as a consultant to USA DENTAC.

5.5 Performance improvement is an integral component of the plan for improvement of practice and patient outcomes.

5.6 Accomplishment of the Infection Control Officer's responsibilities; he/she must establish a working rapport with head nurses, physicians and administrators in the Health Center, keep open lines of communication with all members of the health care team, both professional and nonprofessional, is essential for the circulation of pertinent data. The ICP incorporates the principles of fiscal responsibility, evaluates the quality and effectiveness of the IC plan appropriate to the practice setting.

5.7 Review annually written infection control policies and procedures. Present the revised policies to the Infection Control Committee for approval and upon approval submit policies for duplication and distribute to the unit Infection Control Manuals. Relevant research findings relating to infection prevention and control practice shall be reviewed.

5.8 The Infection Control Officer will be allocated at least 20 hours per week for the performance of the duties and responsibilities of infection control.

6. QUALIFICATION REQUIREMENTS:

6.1 Extensive clinical nursing experience with knowledge of epidemiological principles, infectious diseases, sterilization, sanitation and disinfection practices.

6.2 Attend formal course of instruction in the control of hospital/ambulatory infections.

6.3 Provide documentation of formal instruction.

6.4 Maintain current and active RN licensure.

6.5 Maintains current BLS certification.

6.6 Has a BSN degree or higher.

7. SCOPE OF DUTIES AND RESPONSIBILITIES: The Infection Control Officer at RWBAHC, Ft. Huachuca, AZ has responsibility for the day-to-day management of the Infection Control Program which is directed and monitored by the Infection Control Committee.

INFECTION CONTROL OFFICER
SIGNATURE BLOCK

APPENDIX C
OUTBREAK PLAN

Refer to RWBAHC Emergency Management Plan

APPENDIX D
PUBLIC HEALTH EMERGENCY RESPONSE PLAN

TO RWBAHC Emergency Management Plan

APPENDIX E
GLOSSARY OF TERMS

PURPOSE: Case findings and identification of demographically important HCA infections provide surveillance data.

REFERENCES:

Friedman, C., Petersen, K.H., Infection Control in Ambulatory Care.(2004). Jones and Bartlett Publishers, 40 Tall Pine Drive, Studbury, MA 01776.

Benenson, Abram S.(ed) = Control of communicable Diseases in Man, 15th Edition, American Public Health Association, Washington, D.C., 1990

Dorland's Illustrated Medical Dictionary, 25th Edition. W.B. Saundezs. Philadelphia, 1974.

Stein, Jess (ed), The Random House; college Dictionary, Revised Edition, Random House: Inc., New York, 1982.

Federal Register, "Occupational Exposure of Blood borne Pathogens," 29 CFR, Part 1910.1030,6 Dec 1991.

Federal Register, "Draft Guidelines for Preventing the Transmission of Tuberculosis in Healthcare Facilities," October 12, 1993.

GENERAL: There is considerable variation in definitions of terms among the various sources of medical literature. To provide uniformity, the definitions presented in this Guideline have, where possible, been adapted from standard authoritative sources.

Accidental Exposure - A specific eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other body fluids that results from the performance of an employee's duties.

Acid-Fast Bacilli - Bacteria that retain certain dyes even when washed with an acid solution. Most acid-fast organisms are mycobacteria. When seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be considered; however, the diagnosis is not confirmed until a culture is grown and identified as M. tuberculosis.

Acquired Drug Resistance - Resistance to one or more antituberculosis drugs which develops while a patient is on therapy, usually the result of nonadherence on the part of the patient or inadequate therapy prescribed by a health care provider.

Aerosol, Aerosolization - In TB, it refers to the infectious droplet nuclei that are expelled from a person which can be transmitted to other people.

Air Exchanges - Air flow quantity to a space measured in terms of the room volume, i.e., volume of air delivered + room volume. Usually expressed as number of air changes per hour.

Aneray - The inability of a person to react to skin-test antigens because of defects in the immune system, even if the person is infected with the organisms tested.

Antisepsis - The prevention of sepsis by the inhibition or destruction of the causative organism. Usually refers to substances used on human tissue.

Antiseptic - A substance that will inhibit the growth and development of microorganisms without necessarily destroying them Usually refers to substances used on human tissue.

Asepsis - Freedom from infection: The prevention of contact with microorganisms.

Asymptomatic - Showing or causing no symptoms.

Bacteremia - The presence of bacteria in the blood.
Bactericidal - Capable of killing bacteria.

Bacteriostatic - Capable of preventing bacterial growth but not necessarily capable of killing bacteria.

BCG - (Bacillus of Calmette and Guerin) - A TB vaccine widely used in some parts of the world.

Biohazard - A danger/peril to health of a human being due to living microorganisms.

Blood - The fluid that circulates through the heart, arteries, capillaries, and veins, carrying nutriments and oxygen to the body cells. Includes blood components and products made from human blood.

Bloodborne Pathogen - Pathogenic microorganisms that are present in human blood and can cause disease in humans. These include, but are not limited to, Hepatitis B virus (HBV) and Human Immunodeficiency Virus (HIV).

Body Fluids - All tissues and fluids in the human body that may potentially harbor contagious microorganisms. Body fluids include, but are not limited to, body tissues, cerebrospinal fluid, feces, nasal or respiratory secretions, non-intact skin, pericardial fluid, peritoneal fluid, pleural fluid, saliva, semen, sputum, synovial fluid, urine, vaginal secretions, vomitus, breast milk or amniotic fluid. (F)

Booster Phenomenon - Seen when an individual with infection does not react to tuberculin because his/her body's cell responses to tuberculin have gradually waned over the years. An initial tuberculin test may stimulate (boost) the immune system so that the next test will be positive. This phenomenon is important in infection control in order to distinguish between converters and people who have been infected for a long time, and determine if in fact transmission is taking place. Although the booster phenomenon may occur at any age, it is most frequent among persons over 55.

Cavity - A hole in the lung resulting from destruction of pulmonary tissue. May be caused by TB, but also by other pulmonary infections and diseases. TB patients with cavities in their lungs are said to have "cavity disease" and are often more infectious than patients without cavities. (T)

Communicable - Capable of being transmitted from one person to another.

Community-acquired infection - Infection resulting from the acquisition of the responsible infectious agent before hospitalization. The infection may become manifest before hospitalization, or be in the incubation period at the time of admission to the hospital.

Contact - An individual who has shared the same air as a person with infectious TB for a sufficient amount of time so that there is a probability that transmission of TB has occurred.

Contamination - The presence of a microorganism on a body surface or on /in an inanimate article or substance including water or food. Contamination on a surface does not imply a carrier state. (B) The presence or the reasonably anticipated presence of blood or other potentially infectious material on an item or surface contamination - The use of physical or chemical means to remove, inactivate, or destroy microorganisms on a surface or item to the point where they are no longer capable of transmitting infectious particles an the surface is rendered safe for handling, use, or disposal.

Detergent - Any of a large number of synthetic water-soluble or liquid organic surface-active agents for use in washing. Resembles soaps in the ability to emulsify oils and hold dirt in suspension.

Directly Observed Therapy - (D.O.T.) - An adherence-enhancing strategy in which each dose of medication is ingested by the patient under the supervision of a health care worker.

Disinfect - To free from pathogenic organisms, or to render them inert.

Disinfectant - An agent that frees pathogenic organisms or renders them inert from inanimate objects/surfaces.

Disinfection - The act of removing or rendering microorganisms inert from inanimate objects or surfaces.

Droplet Nuclei - Microscopic particles (1 to 5 microns in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets can carry tubercle bacilli and remain in the air by normal air currents in the room. (T)

Engineering Controls - Controls (e.g. sharps disposal containers, self-sheathing needles, splashguards) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure - The condition of being subjected to something, such an infectious agents, which may have a harmful effect.

Exposure Incident - A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Fomite (fomes) - An object, such as a book, wooden object, or an article of clothing that is not in itself harmful, but is able to harbor pathogenic microorganisms and thus serve as an agent of transmission of an infection.

Germicide- An agent that kills pathogenic microorganisms.

Hand washing Facilities - A facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines. Dispenser- alcohol based hand rub.

HBV - Hepatitis B virus

HEPA (High-Efficiency Particulate Air) Filter - Specialized filter that is
capable of removing 99.97% of particles 0.3 microns in diameter. It may be of assistance in control of TB transmission. Requires expertise in installation and maintenance.

HIV - Human Immunodeficiency virus

Hospital-acquired infection - An infection that originates in the hospital.Synonymous with Nosocomial.

Immunity - That resistance usually associated with the presence of antibodies or cells having a specific action on the microorganism concerned with a particular infectious disease or its toxin.

Induced Sputum - Sputum obtained from a patient unable to cough up a spontaneous specimen. The patient inhales a mist of saline (salt water), which stimulates a cough deep within the lungs.

Induration - The area of swelling that surrounds the site of injection of tuberculin. The diameter of the indurated aria is measured (in millimeters) 48-72 hours after the injection and is recorded as the result of the PPD test.

Infection - An invasion and multiplication of microorganisms in body tissues, resulting in local cellular injury due to competitive metabolism, toxins, intracellular replication, or antigen-antibody response. The immunological response may be transient or prolonged and consists of a cellular response (hypersensitivity) or the production of specific antibody (immunoglobulin) to the components of the infecting organism or its toxins.

Infectious - Caused by or capable of being communicated by infection. (D)

Infectious Agent - An organism (virus, rickettsia, bacteria, fungus, protozoa or helminth) that is capable of producing infection or infectious disease.

Infectious Disease - A clinically manifest disease of man or animal resulting from an infection.

Infectious Waste - See Regulated Medical Waste.

Intermittent Therapy - Therapy given on a twice weekly or three times weekly basis under direct supervision of a health worker.

Intradermal - Within the layers of the skin.

Isoniazid (INH) - An oral drug either used alone to treat TB infection or in combination with one or more other drugs to treat TB disease.

Mantoux Test - A tuberculin test given by injecting a measured amount of liquid tuberculin into the dermis (second layer of the skin) with a needle and syringe. It is the most reliable and best-standardized technique for tuberculin testing.
Mycobacterium Tuberculosis Complex - The complex of mycobacterium species that causes TB; it includes M. tuberculosis, M. bovis, and M. africanum.

Negative Pressure - A term used to describe the relative air pressure difference between two areas of the health-care facility. Air will flow from the higher pressure area into the lower pressure area.

Nosocomial Infection - An infection that originates in the hospital, ambulatory Health Center, or surgery center. The

infection was not present or incubating at the time of admission. The infection may not become clinically manifest until after the patient is discharged. It may also be the residual of an infection acquired during a previous admission.

Occupational Exposure - Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Opportunistic - Capable of adapting to a tissue or a host other than the normal one, usually said of microorganisms.
Parenteral - Piercing mucous membranes or the skin barrier though such events as needlesticks, human bites, cuts, and abrasions.

Pathogen - Any disease-producing microorganism or material.

Personal Protective Equipment - Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g. uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment. Protective equipment includes, but is not limited to, gowns, masks, head covers, shoe covers, gloves, or resuscitation devices.

Positive PPD Reaction - A reaction to the purified protein derivative (PPD) test that suggests the individual tested in infected with tubercle bacilli. Determination of the reaction is largely dependant on interpretation by the person evaluation the test, given the patient's or HCW's medical history and risk factors.

Preventive Therapy - Chemotherapy of TB infection, primarily used to prevent progression of infection to clinically active disease.

Primary Drug Resistance - Resistance of bacteria to drugs which exists before beginning of treatment.

Purified Protein Derivative (PPD) - A type of purified tuberculin preparation derived from old tuberculin (OT) and developed in the 1930's. The standard Mantoux test uses 5 TU (tuberculin units) of PPD.

Purified Protein Derivative (PPD) Test - see Mantoux test.

Purified Protein Derivative (PPD) Test Conversion - Growth in induration within a two-year period after an initial negative reaction with a difference of 10 or more millimeters of induration. Such "conversion" may represent new infection which is associated with a high risk of developing disease, or may occur as a result of the Booster Phenomenon.

Pyrazinamide (PZA) - An oral antituberculosis drug. It is important as a primary drug in short-course treatment regimens. (T)

Regulated Medical Waste (RMW1 - Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed;items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials. (F)

Resistance - The ability of some strains of bacteria (including M. tuberculosis) to grow and multiply even in the presence of certain drugs which normally kill them. Such strains are referred to as "drug resistant strains. (T)

Rifampin - An oral antituberculosis drug which when used along with isoniazid provides the basis for short-course therapy.(T)

Sanitize- To clean and sterilize, as eating/drinking utensils. (D)

Sepsis - The presence in the blood or other tissues of pathogenic microorganisms or their toxins; the condition associated with such presence. (D)

Septicemia - Systemic disease associated with the presence and persistence of pathogenic microozganisms or their toxins in the blood. (D)

Soap - A substance used for washing and cleansing purposes usually made by treating a fat with an alkali. (S)

Source individual - Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, trauma victims, clients of drug and alcohol treatment facilities human remains, and individuals who donate or sell blood or blood components. (F)

Sterile - Aseptic; not producing microorganisms; free from living organisms. (D

Sterility - The state of being free from living microorganisms. (D)

Sterilization - The complete elimination of microbial viability. (D)

Sterilize - To render sterile, to free from microorganisms. (D)

Treatment Failures - Refers to individuals who fail to improve even after a course of chemotherapy is begun, and to individuals whose disease worsens after having initially improved. (T)

Tuberculosis (TB) - A clinically apparent active disease process caused by Mycobacterium tuberculosis complex. (T)

Tuberculin Skin Test - see Mantoux test. (T)

Tuberculosis Case - A particular instance of clinically active TB. It is sometimes used incorrectly to designated the individual with the disease. (T)

Tuberculosis Infection - A condition in which living tubercle bacilli are present in the body, without producing clinically active disease. Although the infected individual has a positive tuberculin reaction, he/she has no symptoms related to the infection and is not infectious. However, the infected individual remains at lifelong risk of developing disease unless preventive therapy is given. (T)

Tuberculosis (TB) Isolation Precautions - Infection control procedures that should be applied when persons with known or suspected infectious TB are hospitalized or residing in other inpatient facilities. These precautions include the use of a private room with negative pressure in relation to surrounding air and removal of air from the room directly outside. Not the same as "respiratory isolation" which calls for a private room, but does not require negative pressure and exhaust of room air to the outside. (T)

Universal Precautions - An approach to infection control iii which all human blood and certain human body fluids are treated as if know to be infectious for HIV, HBV, and other bloodborne pathogens. (F)

Work Practice Controls - Policies and procedures that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles by a two-handed technique). (F)

APPENDIX F
Housekeeping, Clinical Engineering Branch

1. PURPOSE. To establish guidelines and procedures for an effective and efficient housekeeping program for Raymond W. Bliss Army Health Center. These guidelines will also define techniques and practices utilized by housekeeping personnel in the Health Center infection control program.

2. GENERAL. The prime objective of the housekeeping department is to maintain the highest order of aseptic cleanliness throughout the entire Health Center. The degree, to which this objective is achieved, while maintaining attractive surroundings, has a positive effect on the comfort and morale of patients, visitors and the Health Center staff.

3. ADMINISTRATIVE.

a. Hours of work: A clean, sanitary clinic is a very important aspect of the healing process. Therefore, housekeeping employees must work days, evenings, weekends to provide the housekeeping service required. The normal work period consists of five days a week. The determination of daily and weekly work schedules is the responsibility of the Housekeeping Supervisor. It is expected that all employees will comply with the schedule as established by the Housekeeping Supervisor.

b. Confidential Information: When a patient enters the Health Center, the Health Center assumes an obligation to keep in confidence all that pertains to the patient and his affairs. Whether on or off duty, employees will not discuss a patient or give any information about the patient to those not immediately concerned.

c. Smoking: Smoking is not permitted inside the Health Center.

4. RESPONSIBILITIES

a. The House Keeping Supervisor will:

1) Secure approval from the Infection Control Committee (ICC) for the techniques, procedures and supplies utilized by the housekeeping personnel.

2) Continually reevaluate approved techniques, procedures and supplies to improve the quality of housekeeping service in the Health Center. Approval must be secured from ICC for any changes.

3) Continually monitor the quality of housekeeping services through regular inspections.

4) Coordinate with the medical staff to ensure proper procedures are being followed and the proper supplies are being used.

5) Establish an orientation program for all new housekeeping personnel to introduce them to basic Health Center housekeeping considerations and procedures.

6) Establish an ongoing education program for all housekeeping personnel to include both formal and informal training.

b. Housekeeping personnel will:

1) Thoroughly familiarize themselves with this Housekeeping SOP and ensure they follow the techniques, procedures and cleaning schedules established herein.

2) Verify that all cleaning supplies have been approved for use within their work areas.

3) Ensure proper aseptic techniques are used and appropriate protective clothing worn when working in contaminated areas or disposing of contaminated wastes.

4) Ensure rubber gloves and eye protection are worn whenever liquid cleaners are being utilized.

5) Promptly inform the supervisor of any illness, infection or exposure to contamination.

6) Bring to the attention of their supervisor any conditions or procedures observed which they feel are contrary to good housekeeping or aseptic cleanliness.

7) Questions or doubts concerning any of the foregoing must be resolved with the supervisor before any action is taken.

5. DEFINITIONS:

a. Asepsis: The condition of being free from pathogenic organisms to prevent infection.

b. Pathogenic Organism: Organisms which are capable of causing illness.

c. Infection Control Committee (ICC): A committee of professional medical and support personnel responsible for the overall Infection Control Program within RWBAHC.

d. Infection Control Program: A formal program designed to reduce infection within RWBAHC. Housekeeping personnel make a significant contribution through strict adherence to the procedures/techniques herein; through these procedures/techniques, the presence of micro-organisms are reduced and cross-contamination and potential infection of patients as well as visitors and staff is minimized.

6. TRANING OF PERSONNEL:

a. Newly assigned housekeeping personnel are required to attend ten hours orientation training prior to being assigned to a designated area in RWBAHC. The training schedule is as follows:

1) Orientation:

(a) Organization of RWBAHC

(b) Role of Housekeeping

(c) Employee information (annual leave, sick leave, pay scale, promotion, tours of duty).

2) Basic principles of sanitation and disinfection:

(a) Basic bacteriology

(b) Types of disinfectants used in RWBAHC; examples of their use.

3) Safety

4) The care and use of housekeeping equipment

5) Basic housekeeping techniques:

(a) Dusting

(b) Washing

(c) Organization of housekeeping carts

6) Cleaning Procedures:

(a) Floors – swept with treated dust cloth or treated mop, wet-mopping, scrubbing, finishing

(b) Carpeting – vacuuming, shampooing

(c) Patient rooms and bathrooms

(d) Isolation and contaminated areas

7) Waste disposal:

(a) Identification, handling and disposing of trash and waste

(b) Handling and disposing of contaminated trash and waste

8) EE/EO Program

9) Housekeeping Inspections: Quantitative and qualitative standards

b. A continuing education program will be established for all housekeeping personnel to include both formal and informal training.

STANDARDS FOR CLINIC CLEANING

The following cleaning procedures will be utilized in administrative AND outpatient areas of the Health Center.

1. Carpet care:

a. Equipment needed:

1) Shampooer with cold water and carpet cleaner

2) Spot cleaner for carpets

3) Extractor

4) Vacuum cleaner

b. Procedures:

1) All furniture will be removed from the area to be cleaned. Upon removal of the furniture, the area will be thoroughly vacuumed.

2) Spot remover will be used to pre-clean excessively soiled areas and spots. An upright shampooer will be utilized to clean the entire carpet. Particular attention will be given to corners and edges of the area being cleaned.

3) An extractor will be used to remove shampoo and water from the carpet.

4) The entire carpet will be vacuumed after it has been allowed to dry.

5) When furniture is returned to the original locations, cardboard will be placed under metal legs.

2. Walls:

a. Equipment needed:

1) Wall-washing machine

2) Disinfectant or wall-washing compound

3) Ladder

4) Rags or disposable cleaning cloth

5) Bucket

b. Procedure:

1) Before using the wall washing machine, treated dust brooms will be used to remove loose surface dust. This dry cleaning will begin at the floor and work toward the ceiling in long, smooth strokes. A minimum of pressure will be applied to avoid grinding dust into the surface.

2) Using an approved wall cleaner and the wall washing machine, housekeeping personnel will clean the wall working from the top down. Rags or cloth will be used to dislodge stubborn soil not removed by the machine.

3) When one section of the wall has been cleaned, the area will be dried using rags.

3. Windows and glass doors:

a. Equipment needed:

1) Window squeegee – 12”

2) Cleaning cloth

3) Bucket – 10 quart

4) Chamois

5) Razor-blade scraper

b. Procedure:

1) Cleaning solution will be applied with a cloth, using as little as possible. A razor-blade scraper will be used to remove spots. The window will then be scrubbed vigorously with a wet cloth.

2) Starting at a top corner of the window, a squeegee will be used to remove the cleaning solution from the window. Any remaining solution will be drawn to the bottom of the window with the squeegee and collected with a cloth.

c. Special Instructions: The squeegee will be wiped dry with a chamois after each stroke. Large windows will be cleaned one half at a time to prevent the solution from drying on the window.

4. Scrubbing and refinishing floors:

a. Equipment needed:

1) One automatic scrubbing machine

2) One bucket, wringer and mop (for removal of excess water)

3) One bucket, wringer and mop (for applying finish)

4) A minimum of two caution signs

b. Procedures for scrubbing and finishing floors:

1) A minimum of two people are required for this operation.

2) When working in corridor, a caution sign “FLOOR IS WET” will be posted to the front and to the rear of the work area. When working area is a room, a caution sign will be placed at the entrance.

3) One man will use the automatic scrubbing machine to scrub the floor and remove the water. Excess water will be removed using the regular mop, wringer and water bucket.

4) The second man will apply the finish so that one half of the corridor remains clear for through traffic.

5. Stripping floors:

a. Equipment needed:

1) Automatic floor machine

2) Four buckets of water (1 hot, 1 cold)

3) Two water mops

4) Approximately three packages of green pads

5) One large plastic bag of rags

6) A minimum of two caution signs

b. Procedures used in floor stripping:

1) A minimum of two people are required for this operation.

2) When working in corridors, a caution sign “FLOOR IS WET” will be posted to the front and to the rear of the work area. Additional signs will be posted at intersections entering the work area. When work area is a room, a caution sign will be placed at the entrance.

3) One man will begin to lay stripper solution lengthwise, on one half of the corridor permitting normal traffic flow on the other side. The stripper solution will be left on the floor approximately 10 minutes, after which the automatic floor machine will be used to remove all the old finish and sealer from the floor.

4) A second man will use hot rinse water to remove the stripper solution. This rinse will be followed by three with cold water.

5) Housekeeping personnel will spot clean baseboards and the lower section of walls to remove any spots from the stripping or finishing process.

CLEANING PROCEDURES FOR OUTPATIENT AND ADMINISTRATIVE AREAS

The following cleaning procedures will be utilized in administrative and outpatient areas of the Health Center.

1. Administrative offices, outpatient clinics and open areas (lobbies and waiting room).

a. Equipment needed:

1) Glass cleaner

2) Furniture polish

3) Disinfectant

4) Spray spot cleaner

5) Disposable washcloths

6) Cleaning rags

7) Treated dust mop

8) Rubber gloves

9) Waste basket liners

10) Vacuum cleaner

b. Procedures for offices and outpatient clinics:

1) Fill paper towel dispensers in all physician offices, examination rooms and bathrooms.

2) Empty all wastebaskets and replace liners. The inside of wastebaskets in clinics will be cleaned with disinfectant.

3) Wipe light fixtures with a disposable washcloth and disinfectant, when needed.

4) Damp dust picture and bulletin board frames using a disposable washcloth and disinfectant.

5) Spot clean walls as required, particularly around door jams and light switches. When scheduled, walls will be thoroughly cleaned IAW Annex A.

6) Dust all furniture, counters and ledges. All wooden furniture will be polished to a high luster.

7) All rugs and overstuffed furniture will be vacuumed.

8) All chrome and brass will be polished.

c. Procedures for open areas:

1) Wipe light fixtures with a disposable washcloth and disinfectant, when needed.

2) Damp dust picture and bulleting board frames, and doors leading into offices using a disposable washcloth and disinfectant.

3) Clean windows with glass cleaner and wipe dry.

4) Spot clean walls as required, particularly around door jams and light switches. When scheduled, walls will be thoroughly cleaned IAW Annex A.

5) Dust all furniture, counters and ledges. All wooden furniture will be polished to a high luster.

6) All rugs and overstuffed furniture will be vacuumed. Particular attention should be given to corners and under furniture.

7) Tile floors will be mopped IAW Annex A. Personnel must ensure that care is taken along mop boards and at door jams to prevent dirt from accumulating.

8) All furniture will be arranged neatly.

2. Restrooms for outpatient use:

a. Equipment and supplies needed (ensure the cart contains sufficient supplies for the entire shift):

1) Hand soap

2) Paper towels

3) Waste basket liners

4) Toilet paper

5) Mop, broom, wringer bucket, dustpan, rags

6) Porcelain cleaner (cleanser)

7) Disinfectants

8) Toilet bowl brush

9) Rubber gloves

b. Procedures: Janitors tasked with cleaning restrooms are required to perform the following daily:

1) All doorknobs, hinges, door jams, closets and room partitions will be damp dusted before cleaning the rest of the room. All soil and writing must be removed from surfaces to present a net, clean appearance.

2) Toilet bowl cleaner will be put in the bowl and allowed to stand while the housekeeper uses a germicidal detergent to clean fixtures, toilet seat and the outside of the bowl from the top down. When the outside is thoroughly clean, a toilet bowl brush will be directed to under the rim where calcium deposits can develop. The brush will be rinsed by flushing the toilet.

3) A cloth and disinfectant will be used to clean light fixtures and mirrors. The cleaning will begin at the top of the mirror and start down. The mirror will be dried with clean paper towels to prevent water spots on the surface.

4) A disposable washcloth and disinfectant will be used to clean the fixtures of the sink, all porcelain, and plumbing servicing the basin. The paper towel and soap dispensers will be similarly cleaned.

5) Paper towel and toilet paper will be refilled as needed.

6) The walls will be spot cleaned as needed. Particular emphasis must be given to areas around switches, behind the toilet and above sinks.

7) Wastebaskets will be emptied by tying off the liner in each. Before a new liner is inserted in the basked, the interior and exterior surfaces will be cleaned with disinfectant.

8) Floors will be wet mopped with disinfectant solution after all the above steps have been completed.

HANDLING AND DISPOSING OF CONTAMINATED WASTE

1. PURPOSE: To prevent infection by maintaining a clean Health Center environment.

2. PROCEDURE:

a. The following procedures, will be used whenever trash or waste is removed from clinical areas.

1) All waste from patient areas is considered contaminated

2) Bags must be labeled with clinic name and date.

b. Disposable needles and syringes will be placed in impervious, red plastic containers. When the box becomes full, it will be taken to the contaminated waste shed.

c. Non-combustible infectious material such as glass culture plates from the laboratory should be double wrapped in red plastic bags and placed handled as contaminated waste for disposal.

CLEANING SCHEDULES

General:

a. The following procedures will be completed daily during the workweek in all areas of the Health Center.

1) Wastebaskets will be emptied and the liners replaced.

2) Restrooms will be cleaned.

3) All hard surface floors in offices, corridors and elevators will be dusted and damp mopped.

4) All drinking fountains will be cleaned.

5) All paper towel dispensers will be filled.

b. The Family Care Clinic, main lobby and elevators will be serviced by both shifts.

NOTE: Operating Room Cleaning guidelines are covered under the Operating Room Infection Control SOP.

RAYMOND W. BLISS ARMY HEALTH CENTER INFECTION CONTROL RISK ANALYSIS GRID 2006						
Emerging Resistant Organisms						
Scale Key	0 = negligible		1 = low	2 = medium		3 = high
Interpretation Key: Highest score equals highest priority						
Program Component	Effect of Failure High = 3 Med = 2 Low = 1	Have Effective Prevention Approach Yes = 1 No = 2	Impact on Targeted Population High = 3 Med = 2 Low = 1	Frequency of Occurrence High = 3 Med = 2 Low = 1	Detection Ability Yes = 1 No = 2	Risk Score (High Score Priority)
Pandemic Influenza	3	1	3	1	1	9
Hepatitis B & C Transmission	3	1	3	1	1	9
Hand Hygiene	3	1	3	1	1	9
Unprotected Exposure to pathogens	3	1	3	1	1	9
Hantavirus	3	2	2	1	2	10
West Nile Virus	1	1	2	1	1	6
Risks of transmission MRSA /VRE/Klebsiella/Acinetobacter	3	1	3	3	1	11
SARS	3	1	3	1	2	10

Scale Key	0 = negligible		1 = low	2 = medium	3 = high
Interpretation Key: Highest score equals highest priority					
Program Component	Effect of Failure High = 3 Medium = 2 Low = 1	Have Effective Prevention Approach Yes = 1 No = 2	Impact on Targeted Population High = 3 Med = 2 Low = 1	Frequency of Occurrence High = 3 Med = 2 Low = 1	Detection Ability Yes = 1 No = 2	Risk Score (High Score Priority)
Biological Warfare	3	1	3	1	1	9
Small Pox	3	1	3	1	1	9
Anthrax	2	1	3	1	1	8
Viral Hemorrhagic Fever (VHF) Agents	3	1	3	1	2	10
Pneumonic/Bubonic Plague	3	1	3	2	1	10
Viral Hemorrhagic Fever (VHF) Agents	3	1	3	1	2	10
Mass Casualty	3	1	3	1	1	9

Scale Key	0 = negligible		1 =low	2= medium	3= high	
Interpretation Key: Highest score equals highest priority						
Program Component	Effect of Failure High = 3 Medium = 2 Low = 1	Have Effective Prevention Approach Yes = 1 No = 2	Impact on Targeted Population High = 3 Med = 2 Low = 1	Frequency of Occurrence	Detection Ability Yes = 1 No = 2	Risk Score (High Score Priority)
Meningococcal disease (Neisseria meningitides)	2	1	3	1	1	8
Aspergillosis Outbreak	2	1	2	1	1	7
Norwalk Virus (Stomach Flu)	2	1	2	2	1	8
Legionella	3	1	3	1	1	9
Pulmonary Tuberculosis	2	1	1	2	1	7

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Internal Controls/Facility Services

Scale Key	0 = negligible	1 = low	2 = medium	3 = high		
Interpretation Key: Highest score equals highest priority						
Program Component	Effect of Failure High = 3 Medium = 2 Low = 1	Have Effective Prevention Approach Yes = 1 No = 2	Impact on Targeted Population High = 3 Med = 2 Low = 1	Frequency of Occurrence High = 3 Med = 2 Low = 1	Detection Ability Yes =1 No =2	Risk Score (High Score Priority)
Appropriate Isolation rooms	2	2	2	2	1	9
Availability of PPE equipment	3	1	3	1	1	9
Availability Hand Hygiene supplies	3	1	3	1	1	9
Availability of disinfectant	3	1	3	1	1	9
Electricity outage	3	1	3	1	1	9
HVAC Failures	3	1	3	1	1	9
Water Intrusion/Disruption(Flood)	3	1	3	1	1	9
Water Supply	2	1	3	1	1	8
Sterilization and Disinfection	3	1	3	1	1	9
Construction & Renovation Projects	2	1	2	3	1	9

APPENDIX H
DIAPHRAM RING SETS

DEPARTMENT OF THE ARMY
RAYMOND W. BLISS ARMY HEALTH CENTER
2240-E WINROW AVE
FORT HUACHUCA, ARIZONA 85613

STANDARD OPERATION PROCEDURE
FOR DISINFECTING OF ORTHO DIAPHRAGM FITTING SET

1. PURPOSE : This Standard Operating Procedure establishes the guidelines for the disinfecting of diaphragm fitting set(s) in this facility.

2. SCOPE : This Standard Operating Procedure is applicable to all personnel performing the disinfecting of diaphragm fitting set(s).

3. REFERENCES :

a. OSHA Standards, Personal Protective Equipment.

b. APIC Text of Infection Control & Epidemiology, 2nd Edition, Chapter 21.

c. Ortho Diaphragm Fitting Set Cleaning Options, Ortho-McNeil

4. BACKGROUND:

a. Patient care equipment is divided into Spaulding's three general categories (critical, semi-critical, non-critical).

(1) Semi-critical items. Instruments and objects that will contact mucous membrane. These require high-level disinfecting. Diaphragm fitting rings are in this category.

b. High-Level Disinfecting.

(1) Used for items that will come in contact with mucous membranes, but will not enter tissue or vascular system.

(2) PPE to include gloves, gowns and face shields must be worn when using these disinfectants. All instruments/equipment will be rinsed thoroughly with water.

5. PROCEDURE :

a. Wipe off any foreign substances from the ring(s) using a cloth towel or paper towel.

b. Using a liquid detergent and water thoroughly scrub the ring(s). Rinse well with running tap water. Inspect to ensure all foreign material has been removed.

c. Soak in 1:10 dilution of chlorine bleach (e.g. Chlorox 10%) for 30 minutes at room temperature.
PPE to include gloves, gowns and face shields must be worn when using bleach.

d. Rinse thoroughly in running tap water.

e. Soak in 70% ethyl or isopropyl alcohol for 15 minutes.

f. Allow to air dry on clean towel or chux.

g. Store in original container.

The proponent for this publication is the Infection Control Officer.

FOR THE COMMANDER:

Signature Block Commander

APPENDIX I
Guidelines for use of Service/Working Animals

DEPARTMENT OF THE ARMY
R W BLISS ARMY HEALTH CENTER
FORT HUACHUCA, AZ 56813

Infection Control

Guidelines for Service/Working Animals

1. PURPOSE. The purpose of this policy is to provide infection control guidance for service/working animals within RWBAHC while maintaining compliance with the Americans with Disabilities Act (ADA) of 1990.

2. SCOPE. The infection control guidance is applicable to Raymond W. Bliss Army Health Center, including outlying medical clinics that provide care for working animals or may receive persons, i.e., patients, employees, or visitors that require the use of service animals.

3. RESPONSIBILITY. The supervisor of each area is responsible to ensure that all employees within their areas adhere to infection control and Americans with Disabilities Act (ADA) guidelines for service/working animals.

4. DEFINITIONS.

a. Service animal is a legal term defined in the ADA. A service animal is any animal individually trained to do work or perform tasks for the benefit of a person with a disability under the ADA. Examples of service animals include guide dogs, hearing or signal dogs, seizure alert cats, mobility dogs, and emotional support cats. A service animal is trained to not pose a danger to the health and safety of the general public and is not categorized as a “pet” because it is specially trained to help a person overcome the limitations caused by his or her disability.

b. A working animal is an animal that is used by a law enforcement agency, that is specifically trained for law enforcement work and that is under the control of a handler.

c. Handler means a law enforcement officer or any other person who has successfully completed a course of training prescribed by the person’s agency or the service animal owner and who used a specially trained animal under the direction of the person’s agency or the service animal owner.

d. Hand hygiene is the use of soap and running water or alcohol-based hand gel to remove disease-causing organisms from the hands. Hand hygiene is an essential activity in the health care setting because it is the number one method of preventing the transmission (spread) of disease.

5. ADA GUIDELINES.

a. Title III of the ADA requires that places of public accommodation (hospitals, clinics, doctors and dentists offices, laboratories, imaging services) permit the use of a service animal by a person with a disability, unless doing so would create a fundamental alteration or a direct threat to the safety of others or to the facility.

b. The ADA prohibits public accommodations from requiring “certification” or proof of an animal’s training or proof of a person’s disability, for the purpose of access, but does allow employees to question whether or not the animal is a service animal.

c. The service animal will be clean and well groomed. The handler is liable for any damage caused by the service animal.

6. GENERAL.

a. Allow service/working animals access to the facility, unless the presence of the animal(s) creates a direct threat to other persons. The presence of more than one dog in the facility (service or working) can potentially pose a risk. For example, if a working dog is ever sent into the facility, make sure that they do not encounter service dogs, as there would probably be a display of aggression or the military working dog might be distracted from his or her olfactory tasks.

b. If the animal exhibits a condition that presents a threat to others, then the animal may be removed, restricted or denied access to the area. Additional information may be required about the animal if it is necessary to protect public health and safety.

c. If a patient must be separated from his or her service animal while in the health-care facility:

(1) ascertain from the person what arrangements have been made for supervision or care of the animal during this period of separation;

(2) make appropriate arrangements to address the patient’s disabilities while care is administered without the aid of the service animal.

7. Infection Control Measures:

a. If a service animal is epidemiologically linked to an infection or outbreak, the animal must be examined by a veterinarian.

b. Wash hands with alcohol–based hand gel after contact with the service animal, the animal’s equipment, or other items if hands are not visibly soiled.

c. Wash hands with soap and warm water (a minimum of 15 seconds), if hands are visibly soiled or contaminated with proteinaceous material from the service animal.

d. When a decision must be made regarding a service animal’s access to any particular area of the health-care facility, evaluate the service animal, the patient, and the health-care situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk.

e. Animals are not permitted in any areas where sanitary precautions are necessary, i.e., food preparation areas, medication storage and preparation areas, operating rooms, central sterile supply, or recovery rooms. If the need arises to utilize the operating room for a surgical procedure on a working animal, it will be scheduled as the last case of the day and the room will be terminally cleaned by the housekeeping staff. Disposable medical equipment and surgical instruments will be used if possible. If reusable medical or surgical instruments are used in an animal procedure, sterilize them as usual and remove from general service. Label the sterilized items as restricted for use on animals only.

f. Handlers are responsible for the animal and will identify someone for all care of the animal to include feeding, exercising, hygiene and clean up of any accidents in his/her absence. Any animal urine, feces, vomit, or blood, must be removed using appropriate PPE (gloves minimum PPE), followed by cleaning with a hospital approved disinfectant.

g. A private exam room is recommended for any patient that requires the use of a service animal. Animals should not be allowed in isolation rooms particularly contact isolation rooms. The animal is not allowed to come in contact with any patient's non-intact skin (surgical sites, drainage tubes, wounds, etc.).

9. RERERENCES.

a. Duncan, Susan L. APIC State-of-the-Art Report: The Implications of Service Animals in Health Care Settings, 1999.

CDC Guidelines for Environmental Infection Control, 2003.

c. "Epidemiology and Prevention of Nosocomial Infections Associated with Animals" is published in Mayhall's Infection Control and Hospital Epidemiology, 1996.

d. APIC TEXT of Infection Control and Epidemiology, 2nd Edition, 2005 – Service Animals.

e. American with Disabilities Act, Title III regulations, 28 CFR Part 36, 1990, revised July 1994.

f. Duncan SL. APIC state-of-the-art report: the implications of service animals in health care settings. Am J Infection Control 2000; 28: 170-80.

g. Sehulster L., Chinn, R., Arduino, M., et al. Guidelines for environmental infection control in health care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago, IL: MMWR 2003; 52 (No. RR-10): 1-48. http://www.cdc.gov/ncidod/hip/enviro/Enviro_guide_03.pdf

h. Arizona Revised Statutes Title 13, Chapter 29. http://tarlton.law.utexas.edu/dawson/cruelty/az_cruel.htm

i. Arizona Revised Statutes, Title 13, Chapter 11. http://www.know-the-ada.com/serviceanimal1.html

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The proponent for this publication is the Infection Control Officer.

FOR THE COMMANDER:

Commander Signature Block